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YOUNG PREGNANT WOMEN'S DISCURSIVE CONSTRUCTIONS  
OF THE BODY AND HEALTH

By

EMMA A. HARPER

Hon. B.Sc. Human Kinetics, University of Ottawa, 2007

THESIS

presented to the Faculty of Graduate and Postdoctoral Studies  
in partial completion of a  
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## ABSTRACT

The purpose of this thesis was to explore young pregnant women's discursive constructions of the pregnant body and health in the context of the dominant obesity discourse. Conversations with 15 young pregnant women from the Ottawa area were tape-recorded, transcribed, and then analyzed using a thematic and feminist poststructuralist discourse analysis. The results were divided into two articles, the first discussing the women's constructions of health during pregnancy and the second, their constructions of the pregnant body. The narratives reveal that overall the women constitute themselves as neoliberal subjects reproducing dominant patriarchal discourses (e.g., obesity, personal and moral responsibility for health, femininity). Paradoxically, many of these women also show awareness of the contradictions between dominant health and bodily discourses and personal experience, thus leading to alternative and more disruptive subject positions. Impacts, implications, and future research directions are discussed.

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**PART ONE:**  
**EMPIRICAL, THEORETICAL**  
**AND METHODOLOGICAL CONSIDERATIONS**

## CHAPTER I

### INTRODUCTION

Studies on obesity have proliferated extensively over the past two decades. More recently, obesity has become a highly contested issue in scholarly circles (Campos et al., 2006; Gaesser, 2003; Gard & Wright, 2005; Oliver, 2005). However, since this has mostly occurred away from the public eye, Canadians continue to be exposed to information on obesity that is a mixture of scientific, media, and cultural views surrounding the importance of weight and shape. Some scholars have identified a dominant “obesity discourse” (Evans, Rich, & Davies, 2004; Gard & Wright, 2005; Oliver, 2005; Orbach, 2006). This discourse equates health with body weight, where those considered ‘overweight’ and ‘obese’ are regarded as unhealthy regardless of their health practices. Some researchers have also documented the proliferation of the dominant obesity discourse within the health care sector, where medical practitioners and health professionals are emphasizing weight loss over other health measures (Murray, 2007; Scott-Dixon, 2008). This has especially negative effects on women where slimness is already a highly idealized beauty ideal, and may lead to disordered relationships with food and exercise, lower quality of life, and psychological distress (Annis et al., 2004; Darby, Hay, Mond, Rodgers, & Owen, 2007; Orbach, 2006).

There are many recent studies focusing on weight maintenance during pregnancy and the ‘risks’ associated with being ‘obese’ and ‘overweight’ during this period (Baeten, Bukusi, & Lamb, 2001; Jovanovic, 2001; Smith, Hulsey, & Goodnight, 2008). Although, the medical sphere has long dominated pregnancy, including weight gain (Mitchinson, 2002), it is unclear how pregnant women are negotiating the current dominant obesity discourse.

### **Statement of Problem**

Therefore, I wish to examine the connections between the dominant obesity discourse and young pregnant women's discursive constructions of the pregnant body and health. My research objectives are to: a) understand how young pregnant women are discursively constructing their pregnant body, health, and obesity; b) examine the relationship between these constructions and prevailing bodily discourses; c) understand how young pregnant women are interpellated by and position/construct themselves within dominant or alternative discourses on obesity; and d) to understand how these discourses are taken up in their everyday lives.

### **Feminist Poststructuralist Framework & Methodology**

In order to provide a better understanding of how young pregnant women are constituted within discourses surrounding obesity, health, and the body, I will be using a Foucauldian and feminist poststructuralist perspective. Following from a feminist poststructuralist perspective, I will conduct my research from a feminist poststructuralist methodological standpoint, utilizing Kvale's (1996) understanding of the interview as an 'interView'. I will be conducting semi-structured interViews with 15 young pregnant women between the ages of 18-28 in the Ottawa area, recruited using the snowball sampling method. I will then be analyzing these narratives through thematic and feminist poststructuralist discourse analysis (Weedon, 1997; Wright, 1995).

### **Significance of Research**

From a theoretical standpoint this research is innovative in its use of a feminist poststructuralist and Foucauldian framework to investigate how young pregnant women constitute their pregnant

bodies and health in relation to the dominant obesity discourse. On a methodological level, this research is original in its feminist poststructuralist perspective on the way that the obesity discourse is affecting young pregnant women. The use of interViews as a methodological tool has not yet been explored with this population and within this context. Therefore, this research will help to provide alternative ways to view pregnant women's health and body in relation to obesity. Since it will be grounded in empirical accounts of health during pregnancy, it will hopefully provide feminist scholars with additional argument against the patriarchal structures of medicine and science that dominate the discourses surrounding pregnancy, health, and obesity.

Finally, this research is significant because it may provide a deeper understanding of how to improve the health of young pregnant women by looking at their personal experiences of health and obesity during pregnancy and their subsequent actions; thus, providing practical knowledge for health professionals and health interventions aimed at improving pregnant women's health. It may also inform programs and policies aimed at improving the health of young pregnant women with alternative ways to do so based on women's individual experiences.

## **CHAPTER II**

### **LITERATURE REVIEW**

In this chapter, I will begin by discussing previous studies that examined obesity, specifically those authors who criticize the dominant obesity discourse. Secondly, I will concentrate on pregnancy and health. I will pay attention to the rise in literature asserting the ‘risks’ associated with obesity and excess weight gain during pregnancy. I will then look to research that focuses on the various ways that pregnancy has been constructed in Western society, as well as those that have looked specifically at individual women’s construction of their health and body during pregnancy. Lastly, I will look to scholars who have used Foucault to understand the construction of an ideal feminine body within health, exercise, and sport practices, and women’s individual constructions of their bodies in relation to these practices.

#### **Literature on Critical Analysis of Dominant Obesity Discourse**

In this section I will discuss literature that criticizes the dominant understanding of obesity as a public health priority, a disease, and a cause of morbidity and mortality (Campos et al., 2006; Gaesser, 2003; Gard & Wright, 2005; Monaghan, 2005; Oliver, 2005; Ross, 2005). Secondly, I will look to authors who have identified a dominant obesity discourse (Evans, Rich, & Davies, 2004; Gard & Wright, 2005; Oliver, 2005; Orbach, 2006). Within the construction of a dominant obesity discourse, many scholars have identified moral, normalizing, and stigmatizing undertones (Campos, et al., 2006; Gaesser, 2003; Gard & Wright, 2005; Oliver, 2005). Many also discuss how the obesity discourse equates health with slenderness (Gard & Wright, 2005; Oliver, 2005; Scott-Dixon, 2008), and the negative effects that this poses, especially for women (Jutel, 2001;

Orbach, 2006). Lastly, I will discuss authors who identify alternate discourses that resist the dominant obesity discourse (Herrick, 2007; Longhurst, 2005).

### ***Criticism of the Obesity Discourse***

Over the past two decades, information on obesity has grown exponentially. The World Health Organization (WHO) defines overweight and obesity as “abnormal or excessive fat accumulation that may impair health” (2010, par. 1). They go on to emphasize the increase in obesity worldwide over the past twenty-five years. Additionally, the WHO (2010) and others (e.g., Health Canada, 2006; National Institutes of Health, 2008) stress the risks associated with obesity, including heart disease, cancer, and diabetes. Risk is measured through the Body Mass Index (BMI); whereby, as an individual’s BMI increases so does their risk of disease. Therefore, individuals who are obese and overweight (as they are at high risk of becoming obese) should lose weight (Health Canada, 2010). These organizations argue this is most readily accomplished through lifestyle changes such as diet and exercise.

However, many researchers are recently contesting obesity as a major cause of morbidity and the use of the BMI to measure it (Campos, et al., 2006; Gaesser, 2003; Gard & Wright, 2005; Ross, 2005; Scott-Dixon, 2008; Twigg, 2006). Both Ross and Gaesser discuss the many studies that show no increase in relative risk among ‘overweight’ individuals, but have found instead a lower relative risk of premature mortality among ‘overweight’ compared to ‘normal’ or ‘underweight’ individuals. They argue that the BMI is not an accurate marker since a wide range of BMIs correspond to a minimum mortality. Only at the statistical extreme does a high BMI provide a strong correlation with mortality (Campos et al., 2006). Furthermore, the BMI measurement does not take into account other factors that may influence weight including

exercise level, quality of diet, diet drug use, economic status, or family history (Campos, et al., 2006; Ross, 2005). Diet drug use and weight loss surgeries are important factors that may influence the relevance of mortality and morbidity to the BMI measurement since they can be dangerous, possibly life threatening procedures that tend to be used by those who are designated overweight or obese (Campos et al., 2006; Gaesser, 2003; Scott-Dixon, 2008). Rothblum (1990) also argues that stringent and yo-yo diets, which occur at a higher rate among overweight and obese individuals may be a better predictor of ill-health than actual weight.

Therefore, many scholars and health professionals argue that obesity is not a disease in its own right (Campos et al., 2005; Gard & Wright, 2005; Orbach, 2006; Ross, 2005; Scott-Dixon, 2008). Gard and Wright (2005) emphasize that “many fat people live healthy, active productive lives and live beyond the lifespan of many thin people so it seems a nonsense to say that fatness is a disease” (p. 95). Many thin people suffer from the same problems and diseases that are associated with being fat, but they are not labeled ‘diseased’.

Many assert that obesity has been constructed as a medicalized and pathologized state (Boero, 2007; Evans, Rich, & Davies, 2004; Kent, 2001; Monaghan, 2005; Murray, 2007; Oliver, 2005). Oakely (1990) and Morgan (1998) stress that the medical model is based on measurements and statistics. Oakeley (1990) emphasizes that “quantitative methods (large scale surveys, the use of pre-specified scoring methods, for example in personality tests) are cited as...reducing personal experience to the anonymity of mere numbers” (p. 170). The biomedical model minimizes differentiating factors between individuals such as culture, race, class, gender, sexual identity, and disability. Morgan (1998) stresses that this is linked to a belief in naturalistic reductionism: “Various biological factors, functions, and dimensions that constitute each of us at a given time really exist and function in ways that are fundamentally presocial and precultural” (p. 101). Bodies are increasingly controlled through calculability. Boero (2007) argues that

understanding obesity as pathology creates a situation where individuals must look to others for information and knowledge surrounding obesity and their health. The reduction of fatness to biological processes and calculations makes possible its labeling as pathological and a diseased state that requires 'expert' knowledge to fix.

### ***Construction of Dominant Obesity Discourse***

Within the past decade, some scholars have identified a dominant obesity discourse (e.g., Evans, Rich, & Davies, 2004; Gaesser, 2003; Saguy & Almeling, 2008). They stress that beliefs about health and illness "are presented as the voice of biomedical expertise; the experts have authority, power, and authenticity, and there are no uncertainties in the narrative" (Evans, Rich, & Davies, 2004, p. 381). Therefore, this information is quickly disseminated to the public and taken up and distorted in various ways. Saguy and Almeling (2008) argue that fatness is framed in particular ways by the media and medical spheres, putting increased emphasis on individual factors that influence weight rather than social-structural or genetic ones. Furthermore, they discuss the relationship between these two spheres, as scientific information is disseminated to the general public (e.g., through health care providers and the media), and therefore scientists require these avenues to deliver their research to the general population. This may lead scientists to structure their studies and articles in particular ways in order to attract increased media attention (Saguy & Almeling, 2008). Additionally, Evans, Rich and Davies (2004) assert that rarely are the limitations, contradictions, and uncertainties surrounding primary research on obesity and health emphasized in public media. Gaesser (2003) supports this stating that "studies showing the hazards of carrying 'excess' weight frequently engender the most media attention and are the ones highlighted in chapters on body weight and health in nutrition, health, fitness, physiology,

and medical textbooks” (p. 9). Therefore, individuals are exposed to a vast amount of information regarding obesity, health, and weight loss that is lost within public media that emphasizes the negative effects of obesity and individual responsibility for these effects.

Many scholars discuss the stigma associated with obesity (Evans, Rich, & Davies, 2004; Hartly, 2001; Holm, 2007; LeBesco, 2001; Monaghan, 2005); one that is influenced by a wider understanding and judgment of fatness in our culture (Boero, 2007; Evans, Rich, & Davies, 2004; Hartly, 2001). Before the late nineteenth century fatness was judged by visual and functional assessments (Jutel, 2001). Jutel (2001) argues that in the late nineteenth century health began to be quantified and normalized. Insurance companies began to use height and weight charts to exclude ‘at-risk’ individuals from health insurance, and these charts were eventually assimilated by the medical community (Jutel, 2001). Thus, weight became a marker of health (or ill-health). Currently, visual, functional, and quantifiable markers stigmatize the ‘overweight’ and ‘obese’ body (Jutel, 2001; Murray, 2007). Evans, Rich, and Davies (2004) emphasize that whereas, “control virtue, and goodness are to be found in slenderness” (p. 385), fat on the other hand, “is interpreted as an outward sign of neglect of one’s corporeal self: a condition considered either as shameful as being dirty or irresponsibly ill” (p. 376). LeBesco (2001) argues further that individuals who are overweight or obese are usually regarded “as revolting – [and]...agents of abhorrence and disgust” (p. 75). Monaghan (2005) also asserts that visibly overweight individuals are inscribed with inferior social status.

Some scholars argue that obesity is seen as an individual problem that requires individual changes to diet and physical activity to control weight (Boero, 2007; Crandell & Martinez, 1996; Lang & Rayner, 2007; Saguy & Almeling, 2008). This includes an expectation that individuals seek out bio-medical expertise through goods and services to maintain their health (Clarke et al., 2003). Thus, individuals are held accountable for their weight and weight loss and can

consequently, “justifiably be made responsible for safeguarding, monitoring, and regulating their own physical condition” (Lock, 1998, p. 56). Therefore, an individual’s weight is understood as an easily changeable factor that simply requires self-determination and discipline on the part of the individual.

### ***Negative Effects of Dominant Obesity Discourse***

By labeling fatness as unhealthy, many researchers argue that individuals are encouraged to view health as being skinny (Oliver, 2005), and stress that doctors, health promoters and specialists may use fatness as a judgement of individual health (Gard & Wright, 2005; Jutel, 2001; Murray, 2007; Olson, Schumaker, & Yawn, 1994; Scott-Dixon, 2008). In her study with larger female athletes, Scott-Dixon (2008) found that medical and health professionals would label the women as fat and unhealthy even if they were extremely active and physiologically healthy. Murray (2007) also comments that as a ‘fat’ woman she was frequently labeled fat by health professionals and told to lose weight regardless of being seemingly healthy otherwise. Lock (1998) stresses that many clinical practitioners equate illness with identifiable pathology and believe this pathology measurable through the application of technologies. Therefore, the health of individuals is judged based upon physical appearance and abstract measurements such as the BMI. This leads the public and professionals to associate ill health with weight rather than actual health practices such as physical activity and diet. Many women in Scott-Dixon’s (2008) study found that they were first labeled fat by the medical community: “For some women, the qualitative judgment was explicitly linked to quantitative measurements within a specific context, such as medical appointments or weight-loss clinics” (p.33). Olson et al. (1994) found that women considered overweight and obese would delay seeking medical care for fear of

embarrassment and scolding by the medical community. Thus, Scott-Dixon (2008), Murray (2007), and Olson et al. (1994) point to the stigmatization of the 'fat' woman by the very community who is supposed to have her wellbeing as their top priority.

### *Negative Effects on Women*

The implications of the dominant obesity discourse for women are especially prominent. Researchers identify a transition in the feminine ideal, beginning in the 1980's, to that of a more toned and 'worked' body (Hartly, 2001; Gard & Wright, 2005; Jette, 2006; Lloyd, 1996). The slim, toned body is also the one that is emphasized in the dominant obesity discourse as the healthy, productive body (Gard & Wright, 2005). Murray (2008) posits that "what underpins the current 'panic' over 'obesity' in contemporary Western culture is a moral anxiety about the preservation of fixed gender identities and the normative female sexuality and embodiment" (p. 3). Thus, society's obsession with the slim, toned body continues to enforce male/female gender binaries. Additionally, many feminist scholars argue the negative effects the society's obsession with slimness has on women (Bartky, 2003; Bordo, 1993; Jutel, 2001; Orbach, 2006; Wolf, 1990). Orbach (2006) argues that the emphasis on weight in our culture may lead to disordered relationships with food for women of all sizes and shapes. Therefore, even though weight is an individual factor that varies from person to person, equating slenderness with health adds to the pressure that women feel to restrict their diets and obsessively exercise in an attempt to change their weight. Furthermore, this adds to the popular belief that there is a 'right' weight, and that this weight is simply a matter of personal choice.

Some researchers conducted studies documenting the negative impact that the stigma of obesity has on women (Annis et al., 2004; Darby, Hay, Mond, Rodgers, & Owen, 2007). In a

study of women who were overweight, 'normal' weight, or that had been overweight, Annis et al. (2004) documented that the stigma associated with being overweight had negative consequences for women. Overweight women had a higher prevalence of binge eating and lower quality of life. The stigmatizing effect of being obese was related to "greater body image dissatisfaction/distress, weight preoccupation, and dysfunctional beliefs about appearance" (p. 164). Similarly, in a psychological study conducted by Darby et al. (2007), they found that women labeled clinically obese had more eating, weight, and body shape concerns, higher usage of diet pills, binge eating, and fasting, leading to increased levels of psychological distress. These studies point to the possible negative social, psychological, and behavioural impacts of being an obese woman.

### *Alternative Discourse*

Some scholars discuss resistant discourse that opposes the dominant view of obesity as pathology (Herrick, 2007; Longhurst, 2005; McKinley, 2004; Wilson, 2005; Young, 2005). Longhurst (2005) as well as Herrick (2007) discuss the National Association to Advance Fat Acceptance (NAFFA), an American based organization that promotes fat acceptance. Longhurst (2005) argues that "claiming and accepting the word and the identity 'fat' can help individuals to get on and lead positive lives regardless of body size, instead of forever wanting and waiting to be slim" (p. 250). Both Longhurst (2005) as well as Young (2005) argue that space needs to be created for the fat body. Young asserts that "by reclaiming fat and using it as a political tool, a heterogeneity of women's body shapes and sizes could be sponsored. Feminism could employ this technique to advance fatness as a culturally viable, uncontested, female form" (p. 251). Therefore, they argue that making room for the fat female body could further advance the acceptance of fatness in our culture.

However, in criticizing dominant views surrounding obesity, many scholars argue they are not attempting to demonize thinness and support weight gain (Longhurst, 2005; Monaghan, 2007; Scott-Dixon, 2008). Probyn (2008) argues that simply embracing fatness is not a useful strategy: “fat becomes objectified as a mode of resistance. As a viable strategy for social intervention this is painfully limited, and can have quite disastrous political consequences” (p. 403). This reduces women to a mere image, that of the “super-sized female” (Probyn, 2008, p. 402) body, and it ignores the effect that our demand for food is having on the world. Monaghan (2007) goes on to argue that labeling those who are overweight, obese, or fat as healthy may also be a mistake: “Such labeling may itself be a source of poor health, especially for those experiencing material inequalities and discrimination in healthcare” (p. 306). Many researchers also argue that focusing on lifestyle behaviours may be a better strategy to improve well-being (Gaesser, 2003; Herrick, 2007; Oliver, 2005; Scott-Dixon). Gaesser (2003) emphasizes that “if physical activity and diet are viewed merely as means to an end (weight loss), then the millions who fail to achieve and/or maintain weight loss goals might be inclined to revert to a sedentary lifestyle and unhealthful eating habits” (p. 11). Taking the focus away from weight may also reduce the stigmatizing effect on those who appear ‘fat’.

### **Literature on Pregnancy, Health, and the Body**

In this section, I will first discuss claims made by the increasing number of physiological, epidemiological, and medical studies that construct weight gain during pregnancy as a growing risk to mother and child. Afterwards, I will look to authors who have critically scrutinized the dominant discourse surrounding pregnancy, and lastly, I will discuss past literature that has concentrated on pregnant women’s constructions of health and the pregnant body.

### ***Physiological, Epidemiological, and Medical Literature on Obesity and Pregnancy***

Currently, scholars and medical professionals increasingly emphasize risks associated with excess weight gain and obesity during pregnancy. They discuss the increased risk of pre-eclampsia, gestational diabetes, cesarean section, macrosomic infants, and retention of excess weight post-partum (Baeten, Bukusi & Lambe, 2001; Jovanovic, 2001; Smith, Hulsey, & Goodnight, 2008). Smith, Hulsey, and Goodnight (2008) stress that only a small increase in BMI (1-3 Kg/m<sup>2</sup>) could significantly increase these risks even for women who are not already at an obese BMI (p. 179). In addition, Ferraro and Adamo (2008) stress that maternal obesity can lead to childhood obesity: “It may be of even greater importance to note that obesity during pregnancy not only directly affects the mother, but has been implicated in many adverse pregnancy outcomes that can influence the child’s short and long-term health” (p. 38). Therefore, many researchers stress the importance of interventions to prevent the many risks associated with excess weight gain during pregnancy (Kuhlmann, Dietz, Galavotti, & England, 2008; Polley, Wing, & Sims, 2002; Siega-Riz, Evenson, & Dole, 2004; Weissgerber, Wolfe, Davies, and Mottola, 2006). Exercise is being increasingly emphasized as a means to reduce excess weight gain during pregnancy and reduce post-partum weight retention (Damm, Breitowicz, & Hegaard, 2007; Davies, Wolfe, Mottola, & MacKinnon, 2003; Riemann & Hansen, 2000; Weissgerber et al., 2006). Kuhlmann et al. (2008) emphasize that pregnancy is an ideal time for intervention since women have closer and more frequent contact with the health care system. Thus, pregnancy is becoming increasingly targeted by the health care sector as an ideal time for weight loss strategies during and/or after pregnancy.

### *Constructions of Pregnancy*

Feminist scholars have long argued that the female body is constructed as problematic and deviant compared to its male counterpart since the male body is understood as the 'normal' working body (Martin, 1987; Mitchinson, 2002). Additionally, women have been traditionally constructed as inferior to men (Bordo, 1993). Martin (1987) posits that there is a belief that "women are intrinsically closely involved with the family where so many 'natural', 'bodily' (and therefore lower) functions occur, whereas men are intrinsically closely involved with the world of work where... 'cultural', 'mental' and therefore higher functions occur" (p. 17). It is believed that women are connected more closely to their bodies because of biological functions most prominently childbirth; thus, women are considered inferior. This is especially true during transitional periods such as pregnancy where the pregnant body is constructed as increasingly abnormal, emotional, and irrational when compared with the non-pregnant body (Lupton, 1999; Mitchinson, 2002). Longhurst (2001) argues that the pregnant body defies appropriate spacial boundaries and is a leaking, secreting body (through bodily functions such as water breaking, birthing, and lactation). This enhances the understanding of the pregnant body as an abnormal and abject body. Therefore, the pregnant woman is usually represented as sick, emotional, irrational, and inferior within Western culture. The understanding of the pregnant woman as a patient and in need of special care has its roots in the late eighteenth hundreds.

At the end of the nineteenth century, pregnancy became increasingly under medical surveillance, leading to an understanding of pregnancy as pathology and the construction of the female body as problematic and inferior (Mitchinson, 2002; Oakely, 1980; Treichler, 1990; Young, 1990). Mitchinson (2002) argues that in the first half of the twentieth century, Obstetrics established its authority over pregnancy by aligning with sciences. Technology and

standardization created a reliance on medical practitioners during pregnancy (Martin, 1987; Mitchinson, 2002; Lupton, 1999). Through the use of technology, physicians were able to become more aware of the patient's body than the patient, increasing dependence on medical expertise. Secondly, during this same time period, the use of standardization created a normal standard for the working, healthy body. Therefore, pregnancy was no longer judged by personal experience, but through norms and technology. Mitchinson (2002) argues that in the early twentieth century doctors and women who considered themselves modern did not believe in listening to the advice of mothers and grandmothers with regards to pregnancy practices: "This attitude denied women's experience and culture, and paved the way for increasing dependence on medical professionals" (pp. 109-110). Therefore, these scholars argue that due to the professionalization and standardization of Obstetrics, and rise in technology, hospitals, and laboratories, medical professionals increasingly provided the dominant discourse on accepted actions during pregnancy.

Many feminist scholars have commented on the extent to which medical advice pervades every aspect of pregnant women's lives (Lupton, 2001; Mitchinson, 2002; Oakely, 1980; Pollitt, 2008). Mitchinson (2002) argues that physicians began pushing for prenatal care in the early twentieth century. She emphasizes that the physician "was to direct the kind of housework she did, her way of living, and her leisure-time activities, as well as her diet, sexual activity, and the amount of sleep she was to get" (p. 130). Weir (2006) argues that care for the fetus became vital in the early 20<sup>th</sup> century because while infant mortality was decreasing, deaths close to birth remained problematic. Additionally, the declining birthrate of the middle class white Anglo Protestant population coupled with increased immigration from Southern Europe were thought to endanger the quality and quantity of the Nation (Weir, 2006). Thus, physicians began targeting practices related to fetal and neonatal mortality. By creating life before birth "it consolidated the

existence of the living subject prior to and during birth, providing a rationale for its care” (Weir, 2006, p. 3). Thus, the health of the fetus became a priority, and the pregnant body, a dangerous place requiring constant surveillance.

Currently, many feminist scholars argue that the advice and interventions that pregnant women receive continue to be aimed at protecting the health of her fetus and that pregnant women lose their autonomy and personhood during pregnancy since the health of the fetus is considered paramount (Bordo, 1993; Chavkin, 1992; Longhurst, 2001; Lupton; Martin, 1987; Weir, 2006; Young, 1990). Young (1990) argues that “pregnancy does not belong to the woman herself. It is a state for the developing fetus, for which the woman is a container” (p. 160). The woman acts as incubator for the fetus and is expected to follow all recommendations to deliver a healthy baby.

Many scholars discuss the construction of pregnancy as a risk inherent state that requires continual monitoring and assessment by professionals (Bordo, 1993; Longhurst, 2001; Lupton, 1999; Martin, 1987; Mitchinson, 2002; Weir, 2006). Monitoring and judgment comes not only from professionals, but society in general. Mitchinson (2002) argues that in the late nineteenth century, it was understood that the pregnant woman needed to be watched and controlled by others to protect herself and the growing fetus. This seemed to reflect the more general societal belief that women (and especially pregnant women) were emotional and less rational. Currently, there is a wider array of ‘experts’ extolling their knowledge and authority over pregnant women. Longhurst (2001) and Martin (1987) comment on the continual advice and possibly even legal sanctions that pregnant women receive from doctors, specialists, friends, family, and strangers to change lifestyles, and undergo certain prenatal care and procedures. Society deems necessary the constant interventions and recommendations to pregnant women, otherwise their health and, more importantly, that of the fetus would be at stake.

While the pregnant woman is under constant surveillance and monitoring throughout pregnancy, many argue that she is also viewed as individually responsible for the health of the fetus (Bordo, 1993; Chavkin, 1992; Lane, 2008; Greer, 1984; Lazarus, 1994; Lupton, 1999; Ruhl, 1999). Lupton (1999) posits that with this increasing web of knowledge, surveillance, and regulation of the pregnant body and fetus, there is expectation that women should do everything they can to minimize the risks that may threaten the fetus. Ruhl (1999) argues that the placement of the pregnant woman as solely responsible for the health of the fetus “*simultaneously* casts the pregnant woman as an authority and an agent in the care of herself and her fetus even while it supports a subtext which invokes the very opposite: the irresponsible pregnant woman who endangers the health and well-being of her fetus” (p. 97). Thus, they argue that pregnant women feel the need to control their bodies, according to the prescriptions of ‘experts’, to lower the risks of having an unhealthy baby.

### ***Pregnant Women’s Constructions of Health***

Various researchers looked at the ways that pregnant women construct their health and health practices (Bondas & Eriksson, 2001; Lazarus, 1994; Markens & Browner, 1997; Martin, 1987; Oakely, 1980; Rudolfsdottir, 2000). Devine, Bove, and Olson (2001) assert that pregnancy may be a time when many women change their health practices and beliefs. They stress that “life transitions such as childbearing has been conceptualized as times of change in personal health attitudes and practices due to changes in social networks, health concerns, or resources” (p. 568). Therefore, pregnant women’s increased exposure to medical discourses and this new ‘life stage’ that they have entered may create a change in lifestyle. Markens and Browner (1997) discuss the internalization of prenatal norms surrounding diet. They argue that pregnant women were willing

to accommodate to the discourse surrounding maternal diet; thus upholding the view that women are personally responsible for the health of the fetus. Bondas and Eriksson (2001) also comment on the motivation that women felt to improve their health in order to “safeguard the health of the wished-for baby” (p. 828). The women in their study were also worried that the health of their child would be affected by their unhealthy habits. Therefore, many scholars note that women do internalize dominant (medical and media) discourses upholding the health of the fetus as paramount and the mother as responsible for this health.

On the other hand, some authors also argue that women have individual experiences that may differ from the dominant medical discourse (Markens & Browner, 1997; Mitchinson, 2002; Root & Browner, 2001). Mitchinson (2002) asserts that in the first half of the 20<sup>th</sup> Century,

Each woman had an embodied knowledge of herself that might not correspond to medical opinion. She has a memory of her body, and that memory was probably more real to her than what physicians told her was going on in her body. She could use physicians for her own purpose, adding what they told her to other sources of information-popular literature, other women, and other health advocates. (p. 46)

Markens and Browner (1997) emphasize that the women in their study negotiated the various information that was available to them with regards to dietary changes. They argue that women were also concerned about the ways that pregnancy was affecting their own body and this influenced their dietary habits. Root and Browner (2001) posit that pregnant women negotiate between their own experiences and the knowledge asserted through medical discourse. They emphasize that “despite the homogenizing potential of biomedicine to normalize women’s pregnancy experiences along its own disciplinary lines, there endured through women’s accounts

an ever-present and potent individual agency” (p. 218). Women receive information from many sources not just dominant medical knowledge; thus, there are multiple ways that they may be internalizing and acting upon such knowledge.

### ***Pregnant Women’s Constructions of the Body***

A number of scholars have argued that while the body of the pregnant woman becomes hyper-monitored by the medical field, this surveillance is more relaxed with regards to upholding a feminine body (Bailey, 2001; Longhurst, 2001; Seibold, 2003; Young, 1990). Longhurst (2001) comments that “once a woman is pregnant she is often considered to be no longer sexually available, active or desirable” (p. 53). This may decrease the pressure she feels to uphold the feminine body. Thus, “culture’s separation of pregnancy and sexuality can liberate her from the sexually objectifying gaze that alienates and instrumentalizes her when in her nonpregnant state” (Young, 1990, p. 167). Bailey (2001) also discusses that many of the pregnant women in her study were able to reorient the constructions of their bodies away from the feminine, slender norm during pregnancy. Other scholars also remark on pregnant women’s changing construction of their bodies during pregnancy to that of a mother (Bailey, 2001; Chang, Chao, & Kenney, 2006; Seibold, 2003). Chang, Chao, and Kenney (2006) emphasize that body changes and weight gain were understood as an indication of fetal growth and “whereas, nearly all participants expressed concern about losing their slender body shape, many commented that the changes in their bodies reflected their role as mothers” (p. 151). Thus, the changing understanding of the feminine body from ornamental to functional may lead some women to feel comfortable with their changing bodies.

Within the past decade some researchers have documented an increased emphasis on the feminine ideal even while pregnant (Dworkin & Wachs, 2004; Jette, 2006). Additionally, many scholars argue that women are very aware of their bodily changes during pregnancy, and for some, these changes invoke conflicting feelings regarding weight (Greer, 1984; Young, 1990; Oakely, 1980; Wiles, 1994; Devine, Bove, & Olson, 2000; Bondas & Eriksson, 2001). Consequently, researchers found many conflicting results when discussing the body with pregnant women (Bailey, 2001; Devine, Bove, & Olson, 2000; Earle, 2003; Johnson, Burrows, & Williamson, 2004; Wiles, 1994). Many researchers found that women felt horrible about their appearance and size during pregnancy. Devine, Bove, and Olson (2000) as well as Wiles (1994) found that depending on women's weights before pregnancy they felt more or less comfortable with weight gain; those being heavier feeling more comfortable with their changing bodies during pregnancy. Johnson, Burrows, and Williamson (2004) emphasize that "pregnancy was therefore used as a legitimate reason for gaining weight. However, this still had to be within acceptable boundaries" (p. 367). Gaining weight is perceived as acceptable; however, only to a certain point and in certain places. Earle discusses the various concerns that pregnant women have regarding weight, including when they will begin to look pregnant, where changes on their bodies will happen, and the ease of return to pre-pregnancy weight. The transitory nature of pregnancy also influenced the comfort that some women felt with gaining weight. Bailey comments that some of the pregnant women she interviewed viewed pregnancy as a temporary state and therefore were anxious about their changing bodies and fearful of trying to lose weight post-partum. Therefore, pregnant women's constructions of their bodies are complicated and change throughout pregnancy.

This anxiety may be heightened by the growing emphasis placed on weight during pregnancy in popular media (Dworkin & Wachs, 2004, 2009; Jette, 2006). In Jette's (2006)

analysis of Oxygen magazine's pregnancy tips column she finds discussions and pictures that display women who continue to uphold the feminine ideal during pregnancy. She concludes that, "being pregnant does not allow women to escape the emphasis on body norms characteristic of the fitness industry" (p. 346). Therefore, the emphasis on the ideal slender feminine body while pregnant may lead some women to have a hard time coping with the changes that occur to their bodies.

### **Literature on Foucault, Women, the Body, and Exercise**

Foucault, by focusing on the body and its articulations with power, provides useful tools for feminist scholars who also place the body at the centre of processes of power (Rail & Harvey, 1995). In this section, I will examine how authors have used Foucault to speak about women's health, physical activity, and sport. Firstly, I will concentrate on his earlier works to analyze how interrelations of power work to create discourses surrounding women's health and leisure pursuits that directly impact the construction of their bodies. Secondly, I will investigate how concepts such as the panopticon, surveillance, and the gaze act to create docile bodies within the domain of sport and physical activity (Bartky, 2003; Bordo, 1993). I will also refer to authors who analyzed how sport and physical activity discourses are at odds with the conventional discourse of the feminine ideal and how power relations work to co-opt or create new discourses that continue to uphold female inferiority (Cole, 1994; Duncan, 1994; Eskes, Duncan, and Miller, 1998; Haber, 1996; Jette, 2006; Markula, 2001). The second section will concentrate on articles that explore how women involved in sport and physical activity are actually taking up and navigating the various and often conflicting discourses that are available to them. In this way, I will investigate the creation of subjectivity and the possibilities for agency and resistance. Lastly,

I will conclude with articles that explore Foucault's later work, the opportunity that exercise and physical activity provide for the formation of technologies of the self and an ethics of self-care.

### ***Discursive Constructions of Feminine Bodies***

Foucault's concept of power stresses the notion that it is not something that is wielded over individuals, rather it is an exercise that everyone is caught up in at various articulations: "The new methods of power whose operation is not ensured by right but by technique, not by law but by normalization, not by punishment but by control, methods that are employed on all levels and in forms that go beyond the state and its apparatus" (Foucault, 1978/1976, p. 89). The pervasiveness of power makes it almost impossible to identify any one person or group who exercises this power. Bordo (1993) explains that Foucauldian power relations deny that individuals are consciously directing the overall movement of these relations. They may consciously pursue goals, but do not know that they are helping to direct the shape of these power relations or the shape that it is taking. These relations of power act to create discourse that forms knowledge and truth: "Power...is maintained through language, or rather through the act of discourse that creates, from the very fact that it is articulated, a rule of law" (Foucault, 1978/1976, p. 83). Discourse upholds power, and power creates discourse.

Feminist scholars identified a dominant discourse surrounding gender norms and femininity. Bartky (2003) describes the feminine ideal as "taut, small-breasted, narrow-hipped, and of a slimness bordering on emaciation; it is a silhouette that seems more appropriate to an adolescent boy or a newly pubescent girl than to an adult woman" (p. 28). This dominant discourse is upheld through the exercise of patriarchal power. Morgan (1991) emphasizes this arguing that the beauty ideal that women strive for is not defined by "self-determined and

woman-centered ideals of health or integrity [rather] women's attractiveness is defined as attractive to men" (p. 32). Therefore, women are not striving for a self-created ideal, but one that is literally man-made through dominant patriarchal discourse. This ideal also creates women as inferior. Bartky (2003) comments that:

To succeed in the provision of a beautiful or sexy body gains a woman attention and some admiration but little real respect and rarely any social power. A woman's effort to master feminine body discipline will lack importance just because she does it: her activity partakes of the general depreciation of everything female. (p. 35)

Women are constructed as inferior through their bodies, the work they do on their bodies, and the ideals that they are meant to uphold.

There are various dominant discourses that continue to uphold female inferiority. Medical discourse provides a strong motivation for women to submit to dominant notions of femininity. Murray (2007) discusses the way that medical discourse pathologizes fat bodies, thereby normalizing thin bodies. She emphasizes that "it is useful to think about a normative 'slender' body as not only occupying a space of power and influence, but as a means of projecting onto our perception a kind of 'backdrop' of normalcy that structures our readings/constitutions of certain bodies as normative or aberrant" (p. 364). By constructing the slender body as the normal body, all other bodies are viewed as deviant and in need of fixing. She asserts that the authority of the medical discourse reinforces this norm. She emphasizes this stating that "while the clinical gaze is presumed to stand outside of power, to be unaffected by the discourses that construct us all as body-subjects, it too is necessarily implicated in the reproduction of dominant ways of knowing and being" (p. 367). The medical discourse does not remain within the medical profession. It

becomes prevalent in the general public and is used to uphold the feminine norm of the slender body.

Many sport sociologists conducted discourse analyses of sport and fitness literature to unearth the dominant discourses that are prevalent throughout. With the increase in popularity of fitness and health there is a new feminine aesthetic of the athletic, toned, muscled body. However, this continues to reproduce women's self-worth through work on the body, upholding one homogenized feminine ideal (Cole, 1994). Many scholars identified two dominant discourses surrounding women's health and fitness, both intricately linked with the dominant feminine body ideal. The first, claims that health is synonymous with beauty and secondly, that this ideal is achievable for any woman who takes the responsibility to act (Eskes, Duncan, & Miller, 1998; Duncan, 1994; Jette, 2006; Markula, 2001). Although, these discourses intersect and overlap they will be discussed separately in order to clarify each one.

Sport, aerobics, and fitness are used to advance notions of feminine beauty by equating that beauty with health (Duncan, 1994; Eskes, Duncan, & Miller, 1998; Markula, 1995, 2001). Duncan (1994) isolates a mechanism in fitness texts emphasizing that 'Feeling Good Means Looking Good': "Whereas health may be a private condition that varies from individual to individual, beauty is a social, public standard that admits few variations in our culture" (p. 55). Therefore, individuals feel their health and individual body is under threat, and this is remedied through the public norms of beauty and appearance. Women are bombarded with standards of beauty that are advanced as important for their personal health through fitness, health, and exercise text. Therefore, health is replaced by the importance of looking good. In this way, individuals ignore their true physical health for physical beauty.

Many also found that the texts advance the notion that health is a personal responsibility that any woman can achieve, but this health is connected to the dominant feminine ideal (Bordo,

1993; Duncan, 1994; Jette, 2006; Markula, 2001). Bordo (1993) discusses the claim that women can be free from the private home and liberated to the public arena through personal work on the body. The narratives found in fitness texts motivate women to pursue the exercise and beauty regimes set out by these magazines in order to remedy their low self-confidence and liberate them from other factors that may be impeding their achievements. Duncan (1994) identifies the “Efficacy of Initiative” mechanism which emphasizes that “personal choice and commitment are presented as the keys to a perfect body, which is within the reach of every individual” (p. 53). She concludes by stating that:

Instead of questioning the public, social motive that mandates an almost-impossible-to-achieve body ideal...Shape seems to argue that the eating and exercise regimes the women followed earlier were the wrong ones and that then women themselves were at fault for their lack of personal commitment to this rigid body ideal. (p. 61)

Therefore, this emphasizes the personal responsibility that women have for their health and looking good. Jette (2006) discusses the discourse of personal responsibility for health with regards to pregnancy: “Not only is the expectant mother encouraged to exercise in order to manage her changing body and prepare for labor, but the notion is also conveyed that exercise is linked to a healthy pregnancy” (p. 340). She also emphasizes that the pregnant body is viewed as an at-risk body that must walk a fine line between enough exercise and over-exertion which can be dangerous for the baby. This creates a moral responsibility for the pregnant woman to exercise and maintain a healthy body for the good of the population. Markula (2001), in her study of discursive constructs of body image disorder within magazines, also found an emphasis on women being personally responsible for choosing a healthy outlook on their body. The magazine

dictates that it is up to individual women to control their perception of the images in the magazine, thus, setting women up for failure and the continual need to try to achieve the perfect body. Markula (2001) concludes that dominant discourse in the media constructs a specific female body, and it is the individual woman's responsibility for her bodily and psychological health. Women "continue to believe that it is their individual responsibility to resist the oppressive body ideal because they are free to choose a healthier attitude toward their body image. When taught to focus on themselves, women leave their societal oppression unchallenged" (Markula, 2001, pp. 176-177). The notion of liberation and the freedom to choose are constructed notions that overshadow the responsibility to conform to a fit, slender body ideal.

Other sport sociologists conducted discourse analyses of women in sport. Some found that sport may provide an opportunity to resist dominant notions of femininity. Haber (1996) uses the example of female bodybuilders to emphasize the notion that bodies can subvert the dominant feminine norm. Their large, muscular bodies are subversive to the dominant feminine ideal of passivity and slenderness. However, she resigns that "when bodies resist and threaten to become disruptive, there is a whole host of forces that work to resignify the 'new look', to resignify the subversive body into one more tactic of power/knowledge" (p. 148). Consequently, she and other feminist scholars (Cole, 1993; Markula, 1995) acknowledge that many female bodybuilders become re-eroticized and submissive to the male gaze. Klein (1988) observes this very phenomena within elite sport media. She investigates the discursive production of gender in sport media representation. She finds that sport media legitimizes the marginal position of women in sport. This is accomplished by emphasizing the 'natural' differences between the sexes and through descriptions of female athletes that sexualize their bodies and simultaneously emphasize their physical attractiveness over their physical capabilities. Sport reporting is one avenue through which the discourse of feminine inferiority is upheld. Women are bombarded by

this feminine ideal in sport, fitness, and medical discourse which all uphold dominant notions of female inferiority and the homogenous feminine ideal.

### ***Construction of Docile Bodies***

Foucault (1978/1976) argues that individuals are constituted through discourse, and through specific mechanisms will act to uphold and further this discourse. Helstein (2007) discusses the creation of the feminine subject: “Discourses of gender produce knowledge about the ‘feminine’ and through constraint produce the subject who controls and shapes one’s body in an effort to conform to these homogenous standards” (p. 84). Even if women know that female bodies come in all shapes and sizes, since they are bombarded by pictures of slender, toned bodies and told by medical professionals and through magazines, that being thin is healthy and beautiful, the internalization of the standards of femininity are almost impossible to avoid. Cole (1994) argues that this is because “the ‘surface effects’ of bodily practices and micro-powers erase the labor, time, and conditions that make those bodies possible and desirable” (p. 17). These bodies are thus seen as natural, and the practices to achieve this natural look are subsequently naturalized as well. In Jette’s (2006) work on exercise and health discourses within magazines that target pregnant women, she finds that the images display toned, in shape women who appear to have barely put on weight, creating a “panoptic function, encouraging women to self-monitor their behavior to strive for the ‘yummy mummy’ body” (p. 346). This self-monitoring is viewed as a form of self-surveillance. Feminist scholars explain Foucault’s (1977/1975) concepts of surveillance and the Panopticon in relation to patriarchal power: “A panoptical male connoisseur resides within the consciousness of most women: They stand perpetually before his gaze and under his judgment. Woman lives her body as seen by another, by an anonymous patriarchal

Other” (Bartky, 2003, p. 34). Duncan (1994) explains the function of the Panopticon in women’s lives: “The panopticon functions so effectively because it does so via private self-monitoring” (p. 50). Therefore, women internalize this gaze, and come to view this achievement as a personal quest and responsibility.

Bartky (2003) argues that these forms of discipline create docile feminine bodies. Similar, to Foucault’s (1977/1975) docile bodies:

The disciplinary techniques through which the ‘docile bodies’ of women are constructed aim at the regulation that is perpetual and exhaustive—a regulation of the body’s size and contours, its appetite, posture, gestures and general comportment in space, and the appearance of each of its visible parts. (Bartky, 2003, p. 41)

Women’s dieting and exercising practices become disciplinary techniques to create docile feminine bodies. The internalization of this ideal runs so deep that more extreme disciplinary techniques such as plastic surgery may be employed by some women in order to conform to the feminine ideal (Morgan, 1991).

In addition, through the internalization of the standards of femininity put forth by dominant discourse women come to view their identity as women tied to the very practices that subordinate them. Bartky stresses that “to have a body felt to be ‘feminine’—a body socially constructed through the appropriate practices—is in most cases crucial to a woman’s sense of herself as female and, since persons currently can *be* only as male or female, to her sense of herself as an existing individual” (p. 39). Haber (1996) also emphasizes women’s reliance on the ideal: “Women act in collusion with patriarchal power because they are constituted within discourses that give ‘woman’ meaning as subjects of the male gaze” (p. 141). This can explain

how women can become bearers of their own subjugation upholding the feminine ideal. Therefore, women are created through and perpetuate the discourses that uphold notions of femininity and female subordination.

Rather than being a discourse of female empowerment and resistance to dominant ideology, the ideals of strength and liberation through exercise become co-opted by dominant patriarchal discourse. Instead of being healthy, beauty is equated with health, and beauty being a narrow vision of women causes conformity to a very rigid ideal of what health is. Fitness is seen as a way to achieve the beauty norm. Duncan (1994) comments on the dominant narratives put forth in women's fitness texts:

Given the preferred readings invited by the text, is it any wonder that many women find it difficult to experience their bodies as subject and to regard sport and fitness as meaningful for the intrinsic pleasure they provide; the pure enjoyment of movement, the thrill of mastering skills, the challenge of pitting oneself against a worthy opponent? (pp. 63-64)

Dominant discourse upholds the notion of the feminine, homogenous body linking health and fitness with a slender feminine norm.

### ***Constitution of Individual Subjectivities***

Foucault (1978/1976) proposes that individuals can only create their subjectivities through available discourse. And, unfortunately, the private voices of women are often clouded by the more dominant voices of consumer culture and media (Markula, 1995). However, the female athlete does provide a body that at times subverts the normative feminine body. Cole (1994)

discusses the female athletic body as a suspicious body: “Because of both its apparent masculinization and its position as a border case that challenges the normalized feminine and masculine body” (p. 20). Therefore, some scholars posit that the female athlete still provides the possibility for resistance through its subversive reading of the feminine body (Cole, 1994; Haber, 1996; Markula, 1995). By creating subversive bodies we are forced to come to terms with the new reading that does not equate with the dominant notion of what is female. In this way it may be possible to subvert it.

Women involved in all types of sport and physical activity are forced to juggle the various discourses that are presented to them in the multiple aspects of their lives. It is through women’s everyday lived experiences that the practice of agency becomes possible. As long as there are alternate readings and meanings available, individuals can seek these other possibilities. Some feminist researchers have studied the ways in which women involved in sport and physical activity navigate the various discourses available to them (Chapman, 1997; Chase, 2006; Cox & Thompson, 2000; Markula, 1995). While these researchers found that the dominant discourses were present in these women’s lives, they also found that these women did not take up the discourse unquestionably. Since individuals are continually forming and reforming themselves, the way that they embody discourse is dependent on the individual’s particular situation. Also, even though they may be bombarded by dominant discourse in the media, their personal lives may constitute differing experiences. They may constitute their subjectivities through multiple, possibly contradictory discourses.

Markula (1995) in her research on female aerobicizers asserts that the meaning of aerobics is created by many different voices. Some are in contradiction with others, and women actively make sense of these voices in their lives. She found that the women do work to uphold the feminine ideals of the toned, slender, youthful body. However, they also question this

dominant discourse surrounding the feminine ideal. For example, although, the women wanted firm muscles to 'look good' they also felt aerobics provided greater freedom than other activities that discourage muscle. The women took pride in their muscularity, and some women used aerobics to enhance sport performance. They also identified the women in videos and magazines as being unrealistic and preferred 'normal people' as instructors in their classes. Therefore, these women do question the dominant image of the aerobicizing female body.

Other authors exploring the constructions of femininity in various sporting contexts found that the women had to navigate the often conflicting and overlapping discourses available to them (Chapman, 1997; Chase, 2006; Cox & Thompson, 2000). All found that the athletes constituted their subjectivities within the various discourses surrounding femininity and sport. Chase (2006) found that most of the rugby athletes in her study actively resisted the dominant feminine norm by constructing their bodies in ways that improved them for the game of rugby. Chapman (1997) conducted a study with female lightweight rowers and identifies weight management as a mechanism that is present in both the sporting discourse and that of femininity. She argues that the "athletes' weight management practices should not be viewed solely as an oppressive power external to the athletes' selves, but as technology that athletes may take up and use in different way in the development of their subjectivity" (p. 208). She found that the athletes did not originally lose weight to achieve any feminine norm. However, once achieved, the women found it hard to gain weight again, enjoying their slender bodies. However, the women also resisted the dieting practices by eating what they wanted when not in competition or being uncomfortable with their low weights when in competition. Similarly, Cox & Thompson (2000) found that the soccer players enjoyed the strength and endurance involved in the sport; however, they also tried to balance their strong, muscular bodies with other outward signs of femininity

such as long hair. Most women involved in sport and exercise were aware of the contradiction between their more muscular and built bodies and the dominant feminine ideal.

### ***Formation of Technologies of the Self and an Ethics of Self-Care***

In Foucault's later writings he explains more clearly the possibility that individuals may be able to use bodily practices to exert specific functions perhaps differing from their originally intended meanings. Applying Foucault's later work including, the possibility for technology of self and ethics of self-care is a relatively new study in sport sociology (Rail & Harvey, 1995), and it is even newer for feminist sport sociologists (Markula, 2003). Within the domain of sport and physical activity, technologies of the self and ethics of self-care require individual awareness of the limitations of their practice and the development of critical thought towards that practice. Therefore, while it is from the site of individual experiences that resistance must begin, to reach an ethics of self-care it is not enough to label these experiences as resistant or oppressive. Markula (2003) argues that the practice in itself is not oppressive or resistant: "Practices that seem to cooperate with dominant discourse of femininity such as dieting, fashion, shopping, exercise or cosmetic surgery are not in themselves oppressive. Similarly, practices that seem to openly challenge this discourse, such as rigorous weight training, are not necessarily empowering" (p. 103). Thus, it is not the practice in itself, but rather, what the individual does with the practice. Foucault (2003) discusses the creation of ethics of self-care: "Care of the self is, of course, knowledge [*connaissance*] of the self...but also knowledge of a number of rules of acceptable conduct or of principles that are both truth and prescriptions. To take care of the self is to equip oneself with these truths" (p. 29). Ethics of self-care is not only being able to critically analyze one's own position and being, but also to use this liberty to care for others. Foucault

(2003) emphasizes that “a person who took proper care of himself would, by the same token, be able to conduct himself properly in relation to others and for others” (p. 30). Thus, the individual must develop a critical awareness of how these practices are used as technologies of domination, how it may be possible to transgress such readings, and use these practices of freedom and power to care for others.

Fullager (2003) and Markula (2004) have explored the possibility that some fitness practices have in developing an ethics of self-care. Fullager (2003) emphasizes that new types of leisure can be used to refute normalized femininity and “refuse the dominant logic of health as an outcome of exercise and instead value a relation to the body based on an ethics of attentiveness, of affectivity or care, and even of pleasure” (p. 57). In this way she argues that some fitness pursuits can be used differently than perhaps originally intended. Markula (2004) conducted a study with instructors of a “hybrid mindful fitness form that combines Pilates, yoga, and Tai Chi with western strength training” (p. 302) to discover the potential that fitness practices might have to act as practices of freedom and vessels of change. She emphasizes that “to act as practices of freedom, mindful-fitness practices, such as Hybrid, should increase one’s understanding of one’s self as an ethical being and, consequently, facilitate ways of using power ethically” (p. 311). However, Markula (2004) found that the instructors were not critically aware, nor were they actively exercising their power to develop new body practices. She concludes that it is in the specific use of Hybrid, or possibly any fitness practice, that creates the possibility of it becoming a practice of freedom. Therefore, any bodily practice can act as a form of ethics of self-care if it is embedded in critical awareness and ethical use of power. Markula (2003) goes on to assert that, “it is crucial to consider how researchers can use their power ethically to initiate critical self-reflection in and of women’s sport” (p. 105). The growing body of literature investigating the

liberating potential of sport and physical activity may be a critical first step to understanding its liberating potential.

### **Gaps in the Literature**

The growing medical, physiological, and epidemiological literature on pregnancy and health highlights the increasing emphasis on weight maintenance during pregnancy and the risks associated with excess weight gain and obesity. Feminist scholars have been very critical of the medicalized and hyper-monitored experience of pregnancy, unearthing the power structures and patriarchal discourse that pervade the construction of pregnancy. Many have also looked at the ways that individual pregnant women constitute their health and bodies during pregnancy bringing to light the complicated and often contradictory ways that women understand their health and changing body. In relation to obesity, an increasing number of scholars are critical of obesity studies, bringing up significant questions and debates. The identification of a dominant ‘obesity discourse’ and the negative effects of this discourse provide insight into how obesity has been constructed in Western society. However, the dominant obesity discourse that is increasingly targeting pregnant women is quite new and scholars have only recently begun to understand how the obesity discourse and other related health and bodily discourses are targeting pregnant women. Furthermore, individual women have yet to be asked about how this is affecting their constructions of health and the body.

Growing numbers of feminist scholars are employing a feminist poststructuralist and Foucauldian framework to provide a deeper understanding of how discourse surrounding the feminine body affects women’s constructions of their bodies in various health and exercise contexts, providing invaluable insight into how power and discourse shape women’s lives.

However, this theoretical framework has not yet been used to understand how individual pregnant women constitute their subjectivities through discourse on obesity, health, and the body and may be crucial in developing a deeper understanding of these constructions as well as contributing to theoretical knowledge through its application with new populations and emerging discourse such as obesity during pregnancy.

### CHAPTER III

#### FEMINIST POSTSTRUCTURALIST FRAMEWORK

The purpose of this chapter is to provide an overview of the theoretical framework that will help in understanding young pregnant women's discursive constructions of the body and health. As Weedon (1991) suggests, feminist poststructuralist theory and Foucauldian concepts provide tools to explore meanings as they are intertwined within relations of power: "If the work of Foucault offers feminists a more productive approach to understanding and contesting patriarchal power relations, this is due to its insistence on the relationship between meaning and power and the importance of subjectivity" (p. 52). This chapter thus includes an overview of the Foucauldian concepts of power, biopower, discourse, discipline, surveillance, and subjectivity. Feminist poststructuralist concepts such as patriarchy, gender/sex, performance, and docile feminine bodies are also defined. Lastly, I will discuss the opportunity for agency and resistance.

Poststructuralist thought arose in the 1970s with the work of theorists such as Derrida, Lacan, Deleuze, Guattari, and Foucault. They critique the modernist thought that assumes there is an essential human being, and that scientific progress is a linear process leading to universal emancipation. In contrast, poststructuralists consider individuals to be constituted through language, itself dependent on historical and cultural context. Therefore, there is no universal truth or knowledge since truth is dependent on the context within which it is found. Thus, the meta-narratives constructed to explain the world are rejected because they are considered discourses that have been advanced by those in privileged positions within society; they do not actually produce truth but biased views of knowledge. Therefore, poststructuralists aim to deconstruct language and discourse to discover the ways that these meta-narratives have been constructed and expose the various contradictions and assumptions that underlie them. Instead of meta-narratives,

they suggest the creation of mini-narratives. Since every interaction will produce a different result the infinite productions of these mini-narratives can provide no claims to truth, instead they expose the contradictions within our lives and provide an avenue where “difference, pluralism, irrationality, and paradox can surface” (Rail, 2002, p. 185). These mini-narratives do not propose to identify truth and knowledge, but rather show the various, disjointed intersections of our interactions. Poststructuralists do not suppose any grand theory to explain the world, but rather propose reflection on current ontology, epistemologies, and methodologies (Rail, 2002).

Poststructuralist thought has been contested by feminists such as Hartsock (1996) and Deveaux (1996) because it was introduced by white, middle-class men and rejects an essential unified notion of women. Some feminists also argue that a Foucauldian framework reduces women to passive bodies, removing their agency, and thus being detrimental to feminist goals (Hartsock, 1996; McNay, 1991; Deveaux, 1996). However, many others (Butler, 1999, 2004; Hekman, 1990; Rail, 2002; Weedon, 1991, 1997) support the poststructuralist rejection of grand narratives and universal truths. They use the poststructuralist framework to deconstruct dominant notions regarding gender and femininity. Weedon (1991) emphasizes the importance of deconstructing dominant discourse in the work of feminism: “Deconstruction is a necessary moment in discourse theory; it can produce politically useful insights into the reliance of patriarchy on constructed binary oppositions whose status, far from being natural, is a question of white male social power” (p. 52). In this way feminist poststructuralist theory can be seen as not only an alternative, but a challenge to male hegemonic ideals.

### **Power**

Concentrating on Foucault’s text, *Discipline and Punish: The birth of the prison (1977/1975)*, he describes the construction of power, and the various ways individuals are constrained within

society. Foucault differentiates between the formations of power during the sovereign era and the present. In the distant past, power was wielded over the people by the sovereign with grand displays showcasing the consequences if one disobeyed the rules. Foucault argues that in modern times, power is more subtly exercised. Thus, Foucault (1978/1976) asserts that “power is not an institution and not a structure; neither is it a certain strength we are endowed with” rather he defines power as “a complex strategical situation in a particular society” (p. 93). Power resonates from innumerable points, thus there are no specific divides between those who hold power and those who are oppressed. Foucault (1978/1976) goes on to explain how power is exercised:

There is no power that is exercised without a series of aims and objectives. But this does not mean that it results from the choice or decision of an individual subject; let us not look for the headquarters that presides over its rationality...The logic is perfectly clear, the aims decipherable, and yet it is often the case that no one is there to have invented them. (p. 95)

Therefore, the delocalized form that power takes is not held by any one group and pervades all aspects of human life. Individuals cannot be exterior to power, they act to uphold certain power relations, but do not do so out of conscious decision.

Rail and Harvey (1995) have emphasized Foucault’s concept of power in relation to its applicability to the body. They stress that the work of Foucault can be used to analyze the influence of power on the body because it examines, “knowledge formations, and systems of power that regulate corporeal practices” (p. 165). Therefore, Foucault’s conception of power is a useful tool in analyzing the body in sport and health practices.

## Discourse

Foucault (1972/1969) defines discursive formations as “whenever one can describe, between a number of statements, such a system of dispersion, whenever between objects, types of statement, concepts, or thematic choices, one can define a regularity (an order, correlations, positions and functionings, transformations)” (p. 41). Discourses are created through groups of words spoken and written that create meaning and therefore, through their repeated use and reaffirmation create truth and knowledge (Mills, 1997). Individuals construct discourse; therefore, through interrelations of power, dominant discourses are produced creating a general form of truth and knowledge that most people view as correct and natural.

However, individuals are also constituted through the discourse they create. Therefore, certain actions are accepted and others are viewed as deviant. Maguire (2002) highlights this stating that, “By drawing on systematic knowledge and discourses we frame some actions as more acceptable than another’s, thus indirectly constraining the available avenues of action” (p. 295). Individuals can only be constituted within the available, accepted forms of discourse.

However, discourses are created within their specific history and context, they are not stable over time nor are they necessarily continuous or progressive. Foucault (1978/1976) emphasizes the tenuous nature of discourse: “We must not imagine a world of discourse divided between accepted discourse and excluded discourse, or between the dominant discourse and the dominated one; but as the multiplicity of discursive elements that can come into play in various strategies” (p. 100). Power relations are constantly changing, thus influencing and altering the dominant discourses within society. Discourse can uphold power relations, but also act as a “starting point for an opposing strategy” (Foucault, p. 101).

## **Biopower**

As the population grew in the eighteenth century, the need to control and coordinate it became apparent. Thus, “technologies of population” were created. Foucault (1978/1976) defines biopower as a technique of power. He states that:

One of the great innovations in the techniques of power in the eighteenth century was the emergence of ‘population’ as an economic and political problem: Population as wealth, population as manpower or labor capacity, population balanced between its own growth and the resources it commanded. Governments perceived that they were not dealing simply with subjects, or even with a ‘people’, but with a ‘population’; with its specific phenomena and its peculiar variables: Birth and death rates, life expectancy, fertility, state of health, frequency of illnesses, patterns of diet and habitation. (p. 25)

Biopower emerged as the management of living human beings through the very processes that constitute their existence. This form of power acts to control populations, and manage the production of life. It was conceived as a positive form of power to encourage the production of a healthy and efficient population.

Recently, biopower has come to mean the circulation of a discourse of personal responsibility for health and well-being. Foucault (2003) has linked this to the emergence of liberalism, whereby individuals no longer need to be governed by the state, but must take personal responsibility for their own life. Jette (2006) argues that the effect of biopower is to create docile bodies through the internalization of bodily health practices and hence to protect the health of the population. Therefore, biopower works to create disciplined bodies that participate in their own surveillance, upholding the management of their life processes.

## **Discipline**

Discipline is a “technology of power” (Foucault, 1977/1975, p. 194). The pervasive nature of power that pervades into every aspect of an individual’s life disciplines the body. Foucault (1977/1975) emphasizes the regulatory form of disciplinary power as “the penetration of regulation into the smallest details of everyday life through the mediation of the complete hierarchy that assured the capillary functioning of power” (p. 198). Consequently, the individual becomes disciplined and controlled.

Discipline acts to create docile bodies. Foucault (1977/1975) discusses the creation of docile bodies and suggests that they are bodies that “may be subjected, used, transformed, and improved” (p. 136). This is accomplished through the control of all the details regarding bodily movement. Foucault (1977/1975) goes on to describe the work of discipline on the body:

Discipline increases the forces of the body (in economic terms of utility) and diminishes these same forces (in political terms of obedience). In short it dissociates power from the body; on the one hand, it turns it into an ‘aptitude’ a ‘capacity’, which seeks to increase; on the other hand, it reverses the course of the energy, the power that might result from it, and turns it into a relation of strict subjection. (p. 138)

While discipline may create a body that is more efficient and productive, this is accomplished through the constraint of certain actions.

## Surveillance

Surveillance is the mechanism whereby individuals become disciplined. Surveillance is “a state of conscious and permanent visibility that assures the automatic functioning of power” (Foucault, 1977/1975, p. 201). Surveillance allows for the constant visibility of subjects. This is accomplished through the function of the Panopticon. The Panopticon is a concept that Foucault identifies as critical within the interrelations of power to produce “disciplined bodies.” The Panopticon is based on Bentham’s conception of a prison whereby all prisoners are individually placed in cells. The entire structure is of a circular form with a tower in the middle. This tower provides surveillance of all the cells. The individuals in the cells cannot see into the tower, and therefore cannot know for certainty if someone is watching them. Because of this phenomenon, the individual in the cell becomes his or her own surveillor. Foucault (1977/1975) emphasizes the extent of this surveillance mechanism:

The major effect of the Panopticon: ...to arrange things that the surveillance is permanent in its effects, even if it is discontinuous in its action; that the perfection of power should tend to render its actual exercise unnecessary...in short, that the inmates should be caught up in a power situation of which they themselves are the bearers. (p. 201)

Consequently, people become enforcers of their own actions, upholders of social order, and thus disciplined bodies. The state no longer requires overt forms of punishment and force.

The result of the panoptic function is to create a “gaze” that is constituted everywhere, but held by no particular group. Foucault (1977/1975) describes how power is exercised through the gaze, “In it the 'subjects' were presented as 'objects' to the observation of a power that was

manifested only by its gaze” (p. 188). He goes on to describe the gaze stating that, “they did not receive directly the image of the sovereign power; they only felt its effects - in replica, as it were - on their bodies, which had become precisely legible and docile” (1977/1975, p. 188). No longer is power exercised through obvious displays by the sovereign, rather the subtle exercise of power through the gaze brings the subject into being and consequently, intimately aware of herself and her actions. In this way, power becomes ever present, making all actions visible, while itself, remaining undetected.

### **Subjectivity**

Our subjectivity is historically and culturally formed within available discourses. Weedon (1997) argues that “‘subjectivity’ is used to refer to the conscious and unconscious thought and emotions of the individual, her sense of herself and her ways of understanding her relation to the world” (p. 32). Foucault (1970/1966) asserts that this can only be formed within discourse. He rejects “a transcendental consciousness” and the “knowing subject”, and instead focuses on “a theory of discursive formations” (p. xv). The subject does not exist outside of discourse; rather, she is constituted within it. At the same time, discourse can have no meaning without subjects who become its bearers: “Language in the form of socially and historically specific discourses, cannot have any social and political effectivity except in and through the actions of the individuals who become its bearers by taking up the forms of subjectivity and meanings and values which it proposes” (Weedon, p. 34). Language and discourse constitute the subject; however, the subject, by becoming bearer of specific discourse, also reproduces the meanings and values of a proposed discourse.

The subjects, constituted through discourse, are free to act within the constraints of those discourses. The constraining action of discourse is apparent in which capacities are encouraged

and which are viewed as deviant. The constitution of the self through discourse creates a position whereby, the individual becomes subject to the specific meanings and regulations within that discourse. Weedon (1997) states that “in principle, the individual is open to all forms of subjectivity, in reality individual access to subjectivity is governed by historically specific social factors and the forms of power at work in a particular society” (p. 91). Therefore, the constitution of subjectivity is constricted by the available modes of conduct and knowledge within society.

### **Patriarchy**

Patriarchy is an interrelation of power; whereby, male-centered forms of truth have been advanced as the correct ones. Weedon (1997) describes the feminist poststructuralist view of patriarchy stating that “patriarchy implies a fundamental organization of power on the basis of biological sex, an organization which, from a poststructuralist perspective, is not natural and inevitable, but socially produced” (p. 123). Poststructuralist feminism emphasizes that the meta-narratives created to explain human’s existence were advanced in a male-centric view (Rail, 2002). Other smaller narratives were ignored or rendered inferior. Thus, patriarchy is upheld through power relations since it is an inter-relation of power that acts to produce dominant forms of knowledge, and the actions of the dominant group act to influence those of other groups. These discourses act to uphold the notion of what it is to be a man or a woman and how to act within each role. Various feminists (Bartky, 2003; Bordo, 1993; Haber, 1996) have discussed the socially produced dominant discourses that inform women’s views surrounding their bodies. Bartky (2003) comments that patriarchal discourses inform women’s subjectivities, thus producing, “a ‘practiced and subjected’ body, that is, a body on which an inferior status has been

inscribed” (p. 33). This inferior status is concluded due to the patriarchal discourse that creates women as the ‘other’ and inferior to men.

However, since patriarchy is not natural or fixed feminist poststructuralists assert that there are various positions and voices that can either support or resist this constantly changing patriarchal power structure (Weedon, 1997). Therefore, women’s subjectivities are constituted within dominant and resistant discourses to patriarchal relations of power. Identifying and understanding oneself as gendered and a woman are constituted within these various discourses.

### **Gender and Sex Performativity**

Dominant discourse produces socially constructed gender norms, whereby an assumption of the presumed sexual difference creates a division of the acceptable activities of men and women. Feminist poststructuralist theory views these norms as socially constructed and not based on any essential male or female way of being. Butler (1999) argues that gender and sex are not stable identities but rather “tenuously constituted in time, instituted in an exterior space through a stylized repetition of acts” (p. 179). These stylized acts are bodily movements, gestures, and styles that through their repetition create a naturalized understanding of gender. Butler (1997) argues that gender and sex are achieved through performativity. She defines performativity as “a renewable action without clear origin or end” (p. 40). These actions do not originate with a person or at a certain place thus, leading to the seemingly natural existence of gender and sex. She goes on to assert that these acts are performative “in the sense that the essence of identity that they otherwise purport to express are fabrications manufactured and sustained through corporeal signs and discursive means” (Butler, 1999, p. 173). Performativity displayed upon the body produces the effect of a fixed internal core. However, Butler (1999) argues that since

gender is performative and not a naturally occurring way of being this provides the possibility to reorganize and destabilize gender and sexuality. She emphasizes this stating that, “the possibilities of gender transformation are to be found precisely in the arbitrary relation between such acts, in the possibility of a failure to repeat, a de-formity, or a parodic repetition that exposes the phantasmic effect of abiding identity as a politically tenuous construction” (Butler, 1999, p. 179). Since the terms of gender and sex are continually changing over time and space they are a social creation, and because these norms are socially produced they require continual reaffirmation to remain dominant.

Yet, Butler (1999) calls attention to the strength of this dominant discourse: “The social norms that constitute our existence carry desires that do not originate with our individual personhood. This matter is made more complex by the fact that the viability of our individual personhood is fundamentally dependent on these social norms” (p. 2). This stresses the difficulty posed by the social construction of gender norms. Women’s performativity is restricted to certain acts, and therefore women are created by and continually recreate these norms. Foucault (1977/1975) discusses the strength of these norms stating “the art of punishing, in the regime of disciplinary power, is aimed neither at the expiation, nor even precisely at repression...it refers individual actions to a whole that is at once a field of comparison, a space of differentiation and the principle of a rule to be followed” (p. 182). This field of comparison creates a binary that labels the normal and the abnormal, the dominant and the subordinate, the subject and the object. The continual performative replay of gender binaries influences women’s constructions of their body and health and the actions that they take.

### **Docile Feminine Bodies**

The modern patriarchal view of femininity has been likened by many researchers (Bartky, 2003; Bordo, 1993; Duncan, 1994; Eskes, Duncan, & Miller, 1998; Markula, 1995) to Foucault's notion of docile bodies to create a specific docile feminine body. Foucault (1977/1975) defines docile bodies as "subjected and practiced bodies" (p. 138). Bartky (2003) interprets Foucault's conception of docile bodies stating "the production of 'docile bodies' requires that an uninterrupted coercion be directed to the very processes of bodily activity" (p. 26). She then discusses the various ways that women are constituted as feminine docile bodies through action on the body. She labels these disciplinary practices, technologies of femininity:

The disciplinary techniques through which 'the docile bodies' of women are constructed aim at a regulation that is perpetual and exhaustive – a regulation of the body's size and contours, its appetite, posture, gestures and general comportment in space, and the appearance of each of its visible parts. (2003, p. 41)

Bartky (2003) emphasizes that these practices are processes to create the ideal feminine body that is also an inferior body. Female bodies are portrayed as deficient and inadequate. This is compounded by what Bartky (2003) labels the 'set-up' of the disciplinary project of femininity: "It requires such radical and extensive measures of bodily transformation that virtually every woman who is destined in some degree to fail" (p. 34). Therefore, the creation of docile feminine bodies creates women as subordinate to men in that they are programmed to never feel satisfied with themselves. The internalization of feminine practices naturalizes these procedures.

These practices constitute women's subjectivity, and identity as female. Bartky (2003) emphasizes that "the disciplinary power that inscribes femininity is everywhere and is nowhere; the disciplinarian is everyone and yet no one at all" (p. 36). This diffuse action of power works to naturalize the notion of femininity. Therefore, these dominant discourses are viewed as natural and inform women's (as well as pregnant women's) actions, and thus their perceptions of their bodies and health practices.

### **Agency and Resistance**

Women's subjectivities are constituted through discourse; thus, this is where resistance must begin. Foucault (1978/1976) emphasizes the complicated possibilities of discourse: "Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes possible to thwart it" (p. 101). Resistant discourse always exists in contrast to dominant ones. Therefore, it is within these formations of discourse that power is upheld but also that resistance becomes possible. Weedon (1997) argues that "where there is space between the position of subject offered by a discourse and individual interest, a resistance to that subject position is produced" (p. 109). A woman's personal experiences may differ from the discourse being purported leading to a conflict between the two. Weedon (1997) and Bevir (1999) both assert that women have the capability to reflect on their subject positions, creating the possibility for agency. Weedon (1997) argues that a woman has the capability for agency because she exists as "a subject able to reflect upon the discursive relations which constitute her and the society in which she lives, and able to choose from the options available" (p. 121). However, women can only act as agents when they question and resist societal norms:

As agents, we can draw on the resources society makes available to us to question received norms. We escape the normalizing effects of modern power by exploring limits to authorized forms of subjectivity, by questioning our inheritance – and thus developing an ethics of conduct informed by our personal style. (Bevir, 1999, p. 77)

Therefore, women are all agents but, agency is only exercised when we question and resist the pressure to normalize through our individual behavior and conduct.

## CHAPTER IV

### FEMINIST POSTSTRUCTURALIST METHODOLOGY

My research will follow a feminist poststructuralist methodology. Feminist scholars critique the traditionally positivist nature of research, and thus argue that science is not value-free and neutral. Secondly, they contest the objectifying nature of positivist research that exploits their subjects for personal gains (Gorelick, 1991; Harding, 1987; Sprague, 2005). On the other hand, they assert that the purpose of research is to advance the interests of the participants and create social change, while understanding your own role as a researcher who approaches the research from a biased position. In addition, poststructuralist thought rejects the view of meta-narratives and that meaning and truth are pre-existing and can be found. Instead they emphasize that “with the breakdown of the universal meta-narratives of legitimation, there is an emphasis on the local context, on the social and linguistic construction of a perspectival reality where knowledge is validated through practice” (Kvale, 1996, p. 43). Therefore, a feminist poststructuralist stance stresses the act of research as a joint process with the participant and that meaning and knowledge are created and not found through their interaction.

Following from this belief, I will be using an interView method which Kvale (1996) describes as “an inter change of views between two persons conversing about a theme of mutual interest” (p. 2). The term ‘interView’ is stressed because the researcher is also participating in a conversation with the participant during which time both individuals construct their own meanings together through their interactions and influence on each other. I will analyze the narratives created through my journey with participants using two consecutive methods of analysis. The first will consist of a thematic analysis and the second, feminist poststructuralist discourse analysis.

### **My Location in the Study**

Feminist poststructuralist methodology stresses the influence that the researcher's location within the research study and also society at large may have on the process of data collection and analysis. Being the researcher, I am in a location of power to that of the participant (Sprague, 2005; Kvale, 1996). Kvale (1996) supports this by stating: "The research interview is not a conversation between equal partners, because the researcher defines and controls the situation" (p. 6). Feminist methodology allows us to problematize the types of questions we are asking, and the possible consequences that our research will have on others. Therefore, feminist methodology requires the researcher be reflective of their position within society and how this may influence their research process (Sprague, 2005). I need to be aware of the biases that may influence my research by being a white, heterosexual, middle-class, able-bodied, female. In order to avoid presuppositions that may accompany my societal location and the previous research I have done on my research topic, Kvale (1996) suggests employing 'deliberate naiveté'. This involves being critical of my own presuppositions and developing an openness to new and unexpected phenomena. Being an outsider to the experience of pregnancy, I may lack some of the understandings that these women may have, and they may feel I do not understand their experiences; however, my naivety to the experience may reduce my bias. Furthermore, similarly to Earle (2003) during her research with pregnant women, I can use my 'ignorance' of the pregnant experience to question more fully and thus provide a deeper understandings of the nuances and taken for granted understandings of pregnant women.

### **Feminist Poststructuralist Inter-View Method**

Given my positioning as a feminist poststructuralist, I will be using a feminist poststructuralist interView method (Kvale, 1996; Kvale & Brinkmann, 2009). Kvale (1996) discusses the researcher as a traveler metaphor to explain the use of interViews. He posits that the researcher is on a journey with the participant during which they construct meaning and knowledge together. Kvale (1996) emphasizes that “the research interview is an inter view, an interaction between two people. The interviewer and the subject act in relation to each other and reciprocally influence each other” (p. 35). Through conversing with participants I am not looking for a pre-existing truth or knowledge, rather they are created through my interactions with participants (Kvale & Brinkmann, 2009). Therefore, this method allows for the possibility to explore interesting or unexpected themes that arise throughout the conversation, as opposed to traditional interviewing method where the interviewee is understood as a vessel already containing pre existing information. In addition, the journey that we both experience together may instigate reflection on the part of one or both of the individuals, changing our understandings and beliefs; thus, meaning is not found, but created and possibly changes along the interView journey.

Similarly, a feminist methodology argues that researchers work on behalf of the participants to create social change. Gorelick (1991) asserts that feminist methodology emphasizes “the human agency and subjectivity of the people studied” (p. 460). Thus, the researcher is working with the participant to understand how they constitute their subjectivity within discourse and locate room for resistance in order to bring about change (Weedon, 1997). Therefore, a feminist poststructuralist interViewing method allows for the creation of meaning together through the intimate interaction between researcher and participant leading to an

exchange of information for the mutual benefit of both, as two individuals working together to enact change.

The main topics that I will be covering in my interViews are young pregnant women's constructions of health and the sources of these constructions, the integration of health practices in their everyday lives, and how pregnancy affects their constructions of health. Secondly, I will focus on the constructions of obesity, the sources of these constructions, the effect that pregnancy has on these constructions, and the body (generally and during pregnancy), obesity, and disciplining practices. The full interView guide is located in appendix A.

I will be recruiting 15 young pregnant women from the Ottawa area between the ages of 18 and 28 from differing socioeconomic and educational backgrounds. These women will vary in stages of pregnancy and their number of pregnancy. They will also be followed by various medical specialists, including midwives, general practitioners, obstetricians, gynecologists, and nurses. Lastly, they will be considered (medically) within various weight categories during pregnancy, such as obese, overweight, regular weight and underweight. They will also have gained various amounts of weight based on the Society of Obstetricians and Gynecologists of Canada (2010) guidelines.

I will be recruiting my participants through the use of snowball sampling by first contacting personal acquaintances. I will be contacting personal acquaintances by phone and email to initiate my interViews. Subsequent participants will be contacted in the same way through the mediation of the mutually known participant. Other participants may be recruited through local prenatal programs in the Ottawa area by contacting organizations and personally introducing myself to potential participants. All participants will be sent a presentation text inviting them to take part in the study (please see appendix B). This text also provides a brief overview of the study and what their participation entails. Following acceptance to partake in the

study, a time and location of the participant's choice will be set-up. Prior to beginning the interview, participants will be asked to sign a consent form, outlining the study and the possible risks involved (please see appendix C), as well as a reimbursement form for forty dollars. The interview will last between 1-2 hours in length and if clarifications are needed participants will be asked to participate in another short conversation over the phone at a later date. This research study has been approved by The University of Ottawa Ethics Board (please see the acceptance document in appendix D).

### **Feminist Poststructuralist Analysis of Narratives**

I will be recording the interviews and transcribing them verbatim. Transcription of the narratives will be ongoing as the interviews are conducted. The narrative analysis will be conducted through two methods, first a thematic analysis, and secondly, a feminist poststructuralist discourse analysis. The thematic analysis allows for the identification of themes by regrouping text fragments according to semantic affinity. Texts will be grouped from each participant as well as comparatively between participants. This will allow me to better understand how young pregnant women's situational contexts interact with their experiences and constructions of the body and health. Secondly, in order to provide a deeper understanding of how young pregnant women negotiate dominant or resistant discourses surrounding health, obesity, and the pregnant body, and how they constitute their subjectivities through these discourses, I will be conducting a feminist poststructuralist discourse analysis (Weedon, 1997; Wright, 1995). I will be paying particular attention to the ways that they construct their subjectivities through the available discourse on obesity, and whether they position themselves within dominant or alternative discourse. I will then look to whether these constructions recreate the status quo regarding the

'risks' associated with 'excess weight' during pregnancy, or on the other hand, disrupt current power structures and provide alternative narratives.

### **Trustworthiness**

In order to ensure that the participants are being represented in the way that they want they will receive a mailed version of their transcripts and will be asked to make any desired corrections to it and to send it back to me by mail. This will give participants an opportunity to provide feedback through commentary and changes to the transcripts of their conversation, allowing for a more accurate account of their beliefs and understandings.

Secondly, in order to make sure that my interpretations most closely reflect my participants the results of the study will be summarized in the format of a story involving a hypothetical young pregnant woman's constructions of health and the pregnant body and that story will be sent electronically to the participants. I will also send a second story in the format of diary entries also involving a hypothetical pregnant woman. The diary entries will be based on the women's narratives and experiences of their pregnant body. The participants will then be asked to read the brief story and diary and to send feedback (electronically) on them. I will also include a few short questions to let the participants know what kind of feedback would be useful. This will allow for better representation of my participants ensuring that I am working in partnership with them and on behalf of their interests.

**PART TWO:**  
**RESULTS OF THE STUDY**

**Chapter V**

**'Gaining the Right Amount for my Baby':**

**Young Pregnant Women's Discursive Constructions of Health**

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### **Abstract**

In North America, obesity is increasingly emphasized as a “risk” to the health of mother and fetus leading to a growing number of intervention strategies targeted during pregnancy. At a time when pregnant women are under greater pressure to personally uphold the health of their fetus, understanding the impact of the growing discourse surrounding obesity and health on young pregnant women is critical. Therefore, using a feminist poststructuralist discourse analysis, we explore how pregnant young women construct their subjectivities either within dominant discourse on health and obesity or possibly resistant discourses. Open-ended interviews were conducted with 15 pregnant women between the ages of 18 and 28 and coming from various socioeconomic and educational backgrounds in the Ottawa region. The analysis reveals that these women constitute themselves as fragmented subjects reproducing dominant discourses of maternal responsibility, obesity, and moral and individual responsibility for health and weight while also resisting and reciting alternative discourses. Implications for health promotion and policy strategies are discussed.

**Key Words:** Women, Health, Feminism, Pregnancy, Obesity, Discourse, Poststructuralism

## **‘Gaining the Right Amount for my Baby’:**

### **Young Pregnant Women’s Discursive Constructions of Health**

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

More recently, a number of biomedical studies have focused on the ‘risks’ associated with ‘excess’ weight gain during pregnancy (Jovanovic, 2001; Smith, Hulsey, & Goodnight, 2008). The dominant obesity discourse has likewise transformed to now include references to the necessity of weight control during pregnancy. Exact guidelines regarding appropriate weight gain have surfaced along with recommendations for nutrition and exercise to control weight gain (Kuhlmann, Dietz, Galavotti, & England, 2008; Polley, Wing, & Sims, 2002; Weissgerber, Wolfe, Davies, & Mottola, 2006).

Feminist scholars long criticized the medicalization and pathologization of pregnancy as well as the fact that women’s bodies are increasingly controlled through medical and public

surveillance (Bordo, 1993; Lane, 2008; Longhurst, 2001; Lupton, 1999; Martin, 1987; Mitchinson, 2002; Weir, 2006). Firstly, many feminist scholars argued that the advice and interventions that pregnant women receive are most importantly aimed at protecting the health of their fetus, and that pregnant women lose their autonomy and personhood during pregnancy since the health of the fetus is considered paramount (Bordo, 1993; Chavkin, 1992; Longhurst, 2001; Lupton, 1999; Martin, 1987; Weir, 2006; Young, 1990). Secondly, many scholars noted that despite important social determinants of health, the pregnant woman is increasingly viewed as the sole individual responsible for the health of the fetus (Bordo, 1993; Chavkin, 1992; Lane, 2008; Lazarus, 1994; Lupton, 1999; Ruhl, 1999). The pregnant woman is expected to do everything she can to reduce risks to fetal health in order to deliver the ‘perfect’ baby. The dominant obesity discourse mirrors a growing emphasis on the pregnant woman to self-regulate her body and health in order to reduce possible risks to the fetus while simultaneously being increasingly surveyed by the medical and lay communities.

Various researchers looked at the ways in which pregnant women construct their health and health practices (Bondas & Eriksson, 2001; Lazarus, 1994; Markens & Browner, 1997; Martin, 1987; Rudolfsdottir, 2000). Devine, Bove and Olson (2001) asserted that pregnancy may be a time when many women change their health practices and beliefs. They stress that “life transitions such as childbearing have been conceptualized as times of change in personal health attitudes and practices due to changes in social networks, health concerns, or resources” (p. 568). Therefore, pregnant women’s increased exposure to medical discourse at their new ‘life stage’ may create a change in lifestyle. Markens and Browner (1997) discussed the internalization of prenatal norms surrounding diet. They argued that pregnant women are willing to accommodate to the discourse surrounding maternal diet, thus upholding the view that women are personally responsible for the health of their fetus. Bondas and Eriksson (2001) also commented on the

motivation that women feel to improve their health in order to “safeguard the health of the wished-for baby” (p. 828). The women in their study were also worried that the health of their child would be affected by their unhealthy habits. In sum, many scholars noted that women do internalize the medical discourse upholding the health of the fetus as paramount and the idea of the mother’s responsibility for its health as opposed to ideas associated to structural determinants of health of both mother and fetus (e.g., the physical and social environment).

Other authors looked at constructions of health and pregnancy experience and argued that for some women, such experiences differ from the dominant biomedical norms (Markens & Browner, 1997; Mitchinson, 2002; Root & Browner, 2001). Root and Browner (2001) asserted that pregnant women comply with, but also resist biomedical norms. They suggested that biomedicine may attempt to normalize the experience of pregnancy but that, within women’s accounts, there persists an “ever-present and potent individual agency” (p. 218). The women in their study draw on dominant medical knowledge but also subjugated knowledge, those practices and experiences of pregnancy that do not rely on medical expertise (e.g., embodied feelings), in their decisions about their health practices and beliefs.

The past literature above indicates that pregnant women make decisions about health in complicated and conflicting ways turning to both medical expertise and their own needs and experiences. However, within the current context of a very dominant obesity discourse, pregnant women’s individual constructions of health remain unclear. Therefore, the purpose of this article is to understand young pregnant women’s discursive constructions of health in such context. Additionally, it is important to unpack how the dominant obesity discourse and other health discourses (e.g., maternal responsibility for fetal health) impact on the ways in which women discursively construct their health during pregnancy. By conversing with women about their experiences of health during pregnancy, it becomes possible to understand if and how they are

interpellated by the dominant obesity discourse and/or other dominant medical and cultural discourses that link to pregnancy or the pregnant body. Lastly, given the various and often contradictory subject positions available to women, understanding how they construct their subjectivity within alternative and/or resistant discourses may be a crucial step in disrupting the current medicalized and pathologized constructions of pregnancy, since it may provide alternate ways of understanding health during pregnancy.

### **Approaching Research from a Feminist Poststructuralist Perspective**

Many scholars discuss the value of poststructuralist thought in understanding how power produces individual actions and beliefs in society (Butler, 1997; Sawicki, 1991; Rail, 2009; Weedon, 1997). From this viewpoint, it is important to note that power is not wielded over individuals, but rather exercised from innumerable points (Foucault, 1978/1976). Feminist poststructuralists also posit that power is exercised from a male perspective where socially constructed biological differences are stressed, upholding women's inferiority (Weedon, 1997). Furthermore, concepts such as the 'gaze,' whereby the subject becomes intimately aware of herself and her actions, helps to explain how patriarchal power functions to subjugate women and create 'docile bodies.' Docile bodies are those that "may be subjected, used, transformed, and improved" (Foucault, 1977/1975, p. 136). Bartky (2002) described Foucault's concept of the docile body to define the feminine docile body as one that upholds her subjugation through the very actions that create her as a woman. Women regulate their bodies to uphold a feminine standard, and through this perpetual regulation, become docile feminine bodies. Foucault (1978/1976) also posits biopower as a form of productive power that acts to control populations and manage the production of life. Recently, biopower has come to mean the circulation of a

discourse of personal responsibility for health and well-being. Foucault (2003) has linked this to the emergence of liberalism, whereby individuals no longer need to be governed by the state, but must take personal responsibility for their own life. Therefore, biopower works to create disciplined bodies that participate in their own surveillance, upholding the management of their life processes.

Foucault (1977/1975) argues that power produces the subject through interpellation by certain discourses. Discourse produces our reality and thus creates the individual, their subjectivity as a woman, pregnant woman, and mother. However, subjectivity is not stable or fixed, but rather performative through actions already socially established (Butler, 1997). From this perspective, subjectivity is constituted among and between contradictory discourses opening up the possibilities for resistant positions. Women also have the capability to reflect on their subject positions, creating the possibility for agency (Weedon, 1997).

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

A feminist poststructuralist methodology was used for this qualitative study. Feminist scholars assert that the purpose of research is to advance the interests of the participants and create social change. They argue for this change by challenging women's oppression, questioning taken for granted notions about social order and relations, and practically improving the conditions of women's lives through their research (Sprague, 2005). In addition, poststructuralist

thought rejects the view of meta-narratives and the idea that meaning and truth are pre-existing and can be found (Kvale & Brinkmann, 2009). Therefore, a feminist poststructuralist stance stresses the act of research as a joint process with the participant wherein meaning and knowledge are created rather than found through interaction.

Participants were recruited purposively through snowball sampling and contacting local prenatal programs in the Ottawa area. The sample included 15 young pregnant women between the ages of 18 and 28. We looked to Kvale and Brinkmann (2009) for the use of informal conversations or “interViews” as a way to collect our qualitative materials. From this stance, we considered the narratives created during the interViews not as ‘truths’ to be found buried in a participant, but rather as constructed, specific, and contextual events and understandings that are created through our interaction with this participant. Such narratives are intimately affected by both the researchers’ and participants’ lived experiences (Sawicki, 1991; Weedon, 1997). Thus, both individuals construct their own meanings together through their interactions and influence on each other. Following our approved ethical guidelines, interViews were set up at times and locations of the women’s choice, and the women freely consented to and were able to drop out from the study at anytime. InterViews were tape-recorded and lasted between one and two hours. While we used an interViews guide, participants were encouraged to open up the conversation within the main themes of health, obesity, pregnancy, and the body. The interViews were then transcribed verbatim, organized with the use of NVIVO qualitative data software, and analyzed using both thematic and feminist poststructuralist discourse analyses.

First, our thematic analysis allowed for the identification of themes by regrouping text fragments according to semantic affinity. This was done by grouping the related text fragments of individual participants as well as comparatively between participants. This allowed us to better understand how young pregnant women’s situational contexts interacted with their experiences

and constructions of pregnancy and health.

Second, we conducted a feminist poststructuralist discourse analysis (Weedon, 1997; Wright, 1995). Particular attention was given to the ways in which the women constructed their subjectivities through the available discourses on health, obesity, and pregnancy, and whether they positioned themselves within dominant or alternative discourses. We then looked to whether these constructions recreated the status quo regarding dominant discourses of 'risks' associated with 'excess weight' and other medicalized health discourses during pregnancy or, in contrast, disrupted current power structures and provided alternative discourses.

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

### ***Constructions of Health: 'Controlling my Health for the Health of my Baby'***

The contextual backdrops that frame our participants' lives are important to acknowledge in understanding their constructions of health. The women are all white but come from a variety of socioeconomic and educational backgrounds. The women also vary in trimester, number of pregnancies, and relationship and employment status. These participants also have diverse medical care during their pregnancies (e.g., obstetricians, gynecologists, general practitioners, midwives, nurses, naturopaths) and draw information from more than one source. They also vary

in their description of their weight gain during pregnancy. These characteristics are summarized in Table 1 below.

**Table 1. Self-Described Characteristics of Participants at Time of Interviews**

<b>Attributes</b>	<b>No. of Women (N=15)</b>
<b>Age</b>	
18-21	4
22-25	5
26-28	6
<b>Trimester</b>	
First	2
Second	5
Third	8
<b>Number Pregnancy</b>	
First	11
Second	3* (2 abortions)
Third	1
<b>Education</b>	
University	7
College	4
High school	4
<b>Employment</b>	
Yes	7
No	8
<b>Relationship Status</b>	
Partner	12
Single	3
<b>Weight During Pregnancy</b>	
Underweight	3
Regular weight	7
Overweight	3
Obese/Fat	2

Participants were asked what is health for them, generally, and a number of themes emerge from the analysis of their narratives. The theme of body control is by far the most common and it is associated to narratives around diet, physical activity, controlling weight, and abstaining or decreasing consumption of drugs and alcohol. Other common themes are that

health is having a well-functioning bodily system (lack of sickness, lack of disease, having “working” internal organs), functional ability (e.g., being able to walk up a flight of stairs), psychological and emotional wellbeing, and a personal feeling (e.g., “when I feel healthy”).

Women’s narratives suggest that their constructions of health change during pregnancy; the existence of the fetus becomes forefront in the women’s minds. For them, health during pregnancy is constructed as: (a) something secondary and intimately connected to fetal health; (b) body control through lifestyle factors; (c) something requiring an active search for expert knowledge/appraisal; and (d) a personal feeling influenced by embodied experiences.

In relation to the first theme, all the women are most concerned with their fetus’ health and many speak about how they place fetal health above their own. This is well illustrated in the following excerpts:

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

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

The women’s narratives generally demonstrate the priority that they place on fetal wellbeing over their own. In addition, their health is understood as intimately linked to the health of the fetus. Markens and Browner (1997) found that most prenatal programs and literature emphasize the close relationship between maternal intake (i.e., diet) and fetal health, leading

most women to reproduce this belief. Similarly, our participants construct their health as intricately linked to that of their fetus. Two participants express this link in an explicit way:

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

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

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

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

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

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

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

Connected to the fourth theme is the idea that despite their personal efforts and those of experts to control their body, the participants understand pregnancy as something uncontrollable, as it results in physical experiences such as cravings, aches, heartburn, and nausea that vary greatly in intensity between women. Most participants agree that individual experiences lead some women to experience very 'difficult' pregnancies and others to seemingly have very little control over exercise, food and weight gain. This understanding of the pregnant body has a direct impact on the control they feel they can exert over their health. Lauren confides that "because your hormones come into play, I mean, there's so much that you can't... You can't control it when you're pregnant." Jaime's narrative echoes such notion: "I'm not gaining weight because

I'm unhealthy. I'm gaining weight because it's what happens. Each woman is different, their body works differently." Health and weight gain are simultaneously constructed as controllable through exercise, nutrition, and medical surveillance, and paradoxically uncontrollable and specific to each individual.

### **Dominant and Alternative Discourses on Health and Obesity**

Turning to the discourses that are reproduced through the participants' narratives, it is apparent that the women are interpellated by both dominant and alternative discourses. In order to emphasize the "messiness" and complexity of our participants' narratives, we follow the footsteps of other scholars (Fortin, Cyr, & Tremblay, 2005; Richardson, 1992) and utilize different typeface to depict contradictions. Where the women recite dominant discourse, the font is in normal typeface and where they locate themselves within *contradictory and alternative* discourse, the typeface is *italics*. Participants draw simultaneously on dominant (e.g., medical) and subjugated (e.g., personal or embodied) discourse and navigate these in very telling ways. Thus, we have included excerpts that speak directly to the women's conflict and emotions in order to clearly display the contested and multiple discourses within which the women position themselves in their discursive constructions of health during pregnancy.

#### ***Discourse of Maternal Responsibility for Fetal Health***

Many scholars discussed the increasing emphasis on personal responsibility for health and the need for consumption of products and knowledge to fulfill this responsibility (Clarke, Mamo, Fishman, Shim, & Fosket, 2003; Evans, Rich, & Davies, 2004; Jette, 2006; Markens &

Browner, 1997; Rail, 2009). Clarke et al. (2003) write that “health itself and the proper management of chronic illnesses are becoming individual moral responsibilities to be fulfilled through improved access to knowledge, self-surveillance, prevention, risk assessment, the treatment of risk, and the consumption of appropriate self-help/biomedical goods and services” (p. 162). Pregnant women have even more pressure given that they are expected to uphold not only their own health, but that of their unborn child as well (Lupton, 1999). The women are interpellated by the dominant discourse of maternal responsibility for fetal health (Jette, 2006). As discussed in the previous section, the participants discuss their increased consumption of information through the Internet, books, videos, prenatal groups, and medical specialists, and the motivation to take it upon themselves to prevent or lower health risks through individual lifestyle factors. Amid reproductions of this discourse, many of the women also recite alternative discourse. Some of the women discuss their partner’s involvement in their health and therefore their fetus’ health. This is counter to a dominant discourse of maternal responsibility that largely ignores the role that fathers play in the health of the fetus (Bordo, 1993; Pollitt, 1998). This includes genetic influences, but also external factors such as the social and physical environment of mother and thus fetus. Generally, partners are constructed as a helping factor to achieving optimal fetal and maternal health during pregnancy. However, some of the women also point to negative aspects of their partner’s involvement. For example, Beth first mentions the positive elements of her partner’s contribution, cooking healthy meals for her and providing motivation to be healthier, yet she later expresses frustration towards his judgment of her health practices, but not following them himself. When asked how this makes her feel, she replies:

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

Beth draws on alternative discourse (demonstrated in *italics*) as she discusses her partner's role in the fetus' health. However, tension is apparent in Beth's narrative as she points to her partner's involvement, but also suggests that ultimately fetal health is her responsibility and hinges on her 'choices.' The women's feeling of personal responsibility seems directly connected to discourses available to them, which they appropriate as their own (Weedon, 1997). To elaborate on the productive possibilities of disciplinary power, Haber (1996) emphasizes that, "women act in collusion with patriarchal power because they are constituted within discourses that give 'women' meaning as subjects of the male gaze" (p. 141). In the case of our participants, their subjecthood rests on their actions as 'mothers', more specifically as 'good mothers' discursively constructed through the medical and social gaze. Our participants thus strive for this status even while it may mean upholding their subjugation. The women do discuss outside pressure to be "good mothers" and to "be healthy" but have largely internalized this pressure. The following excerpt from Karen's narrative speaks to this:

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

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

### ***Obesity Discourse and Gaining the 'Right' Amount***

The dominant obesity discourse stresses weight maintenance as a defining characteristic of health (Gard & Wright, 2005, Rail, Holmes & Murray, 2010). Currently, this includes weight control during pregnancy. Medical guidelines provide exact weight stipulations for pregnant women, stressing that being inside the recommended weight category is part of pregnancy health (Polley, Wing, & Sims, 2002). Almost all the women discuss their awareness of weight recommendations, and many see this weight as part of being healthy, positioning themselves within the dominant obesity discourse. Vanessa, who is 'underweight,' accommodates to the weight guidelines. She negotiates between dominant medicalized discourse and other conflicting cultural discourse when she states:

*Yeah, I think I would never worry about it if I wasn't reading the information right. And again, if I was in a different culture, probably nobody would care how much I weighed, you know what I mean. But I think because the information is written black on white that, at this point, at 28 weeks, I'm supposed to be anywhere between 16 and 24 lbs, and I'm at 12, I've gained, you know what I mean? So for me, I'm like between 12 and 16. Am I doing something wrong? Is the baby going to be too small at birth, you know, is it going*

to affect her health? Almost probably because I'm thinking that if I'm not following the guideline then I'm not at my optimal pregnancy health. Do you know what I mean? *It's almost like a link that you make in your mind whereas it's probably not true.*

This is similar for other women who are 'underweight' during pregnancy. They believe that they are probably healthy, but because of the growing expectation to be a certain weight in Western culture, they feel anxious and worried. Despite her awareness of alternative cultural discourses, Vanessa still feels uncomfortable about being outside the guidelines for a 'normal and healthy' pregnancy. Some participants who are 'overweight' during pregnancy also have multiple positions within the discursive formation related to pregnancy and weight. For instance, Jaime first rearticulates a dominant discourse on health expertise, trusting her doctor and nurses the most:

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

Simultaneously though, Jaime puts a lot of emphasis on other women's experiences as well as her own understanding of her body. This is emphasized later in the interviews when she disregards medical weight gain recommendations and looks to her mother for guidance and reassurance. Notably, she discusses her confrontation with a nurse over gaining more weight than recommended:

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

Therefore, Jaime outright resists dominant medical and obesity discourses that stress "excess" weight as a threat to her fetus' health. She turns instead to her own experience and that of her mother. She uses resistant discourses to understand her health during pregnancy in alternative ways. Like Jaime, some women do not support the view that they need to be a certain weight, however all agree that lifestyle factors such as nutrition and exercise are determinants of health and fetal health.

### ***Discourse of Mother Blame: Moral Responsibility for Fetal Health***

The understanding that exercise, diet, and weight control are an individual choice and responsibility leads to the moral stigmatization of those who do not conform to dominant 'health' ideals (Evans, Rich, & Davies, 2004). During pregnancy this is exacerbated, as women are considered personally responsible for the health of the fetus and culpable for any health problems during pregnancy, supporting a discourse of mother blame (Pollitt, 2008). Jette (2006) discussed

the concept of biopower as it relates to the pregnant body. She explains that pregnant women may internalize bodily health practices, thus upholding themselves as personally responsible for fetal health and thus the health of the nation through their actions. Therefore, those who do not uphold recommended health practices (e.g., nutritional and exercise guidelines) are seen to have failed as (future) mothers. Some of the women in our study reproduce discourses of health as controlled by individual lifestyle factors and a moral responsibility. Specifically, the meaning of 'eating for two' has shifted for many of the women: no longer an accepted indulgence during pregnancy, many consider it within a discourse of moral failure, since dominant medical discourse emphasizes calorie control during pregnancy. Additionally, they discuss laziness and gaining 'excess' weight as features associated to an irresponsible pregnant woman. Some of the women discuss cultural differences surrounding weight gain, displaying their awareness of alternative discourse reconciling fat and pregnancy. However, most accommodate to Western norms and some go on to condemn those women who do not uphold such norms. Both discursive positions are sometimes adopted by the same participant, as is the case for Vanessa:

Like, you know, I would hate to see anyone be pregnant and smoke and drink and eat burgers all day... I just, for some reason, have the image that a pregnant woman should, I guess, be more conscious of her health and should, you know, make more efforts to be healthy to make sure her baby will be healthy... I wanted to make sure that I wouldn't be one of those who gained, you know, 70 lbs. I don't want to be someone who wakes up at 3am and wants egg rolls [laughs]. Because I just don't think that that's a good idea for me, for my perception of pregnancy health.

Above, Vanessa notes that gaining too much and indulging cravings is wrong. But later, she is quite critical of the “restrictive” features of the dominant (i.e., medical) approach to pregnancy and demonstrates awareness of an alternative cultural discourse that celebrates weight gain during pregnancy:

*It's certainly a medical approach, I mean you're followed closely, you have guidelines for everything: how much weight you're supposed to gain, how many calories you're supposed to have... So it's a lot more of a medical and a lot more restrictive approach... So it's interesting but because I live here and this is the environment that I'm in, and because this is the information that I have access to, I follow it. I just find it interesting to know that elsewhere in the world, you put on 70 lbs, wonderful, you're a healthy pregnant woman.*

This last excerpt points to Vanessa's awareness of alternative cultural discourse during pregnancy. However, because they live in a Western culture, many women, like Vanessa, accommodate to the guidelines and perpetuate the idea of moral failure among women who do not uphold them. Therefore, it is apparent that many of the women internalize dominant medical discourse that stresses individual lifestyle factors as the main determinants of maternal and fetal health, expecting pregnant women to be ever vigilant of their physical activity, nutritional intake, and weight gain.

### ***Contradicting the Medical Discourse: Embodied and Individual Experiences***

It is clear that the women are interpellated by the dominant medical discourse surrounding pregnancy. They recite discourses of maternal, individual and moral responsibility

for health, and lifestyle factors as simple controls for weight and health. However, many times the women's personal experiences demonstrate a lack of control and feelings of powerlessness in the face of increased expectations. Much of this lack of control stems from their embodied experiences (e.g., cravings, aches, tiredness, nausea). For example, Cherry discusses the need to 'give into cravings.' She negotiates these embodied urges (underlined typeface) with the dominant medical discourse (regular typeface) surrounding the importance of resisting 'bad' foods for the fetus' health in the following excerpt:

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

Cherry is interpellated by dominant obesity and medical discourses as she goes to great lengths to control weight gain and follow nutritional recommendations, even while her embodiedness contradicts these discourses. Medical discourse also stresses the importance of exercise for maternal and fetal health and to control weight gain (Weissgerber, Wolfe, Davies, Mottola, 2006). The women appropriate this discourse, but also express difficulty maintaining the guidelines due to embodied feelings. This tension is apparent in the following statement:

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

(Amanda)

Amanda's reproduces a medical discourse but embodied experiences play a large part in the control she feels she exert over her exercise levels. For other women, the embodied feelings and personal experiences sometimes lead to worry, anxiety, and doubt about their own health and that of their fetus as they conflict with the dominant medical and obesity discourse.

### **The Fragmented Subject: Impact and Implications**

Due to the negotiation between contradictory dominant and alternative discourses, the women construct their subject positions as fragmented. On the one hand, the women locate themselves within discourses of maternal responsibility, personal control over weight and health, and condemnation of those women who do not uphold health ideals: they seem to be typical neoliberal self-authored subjects. On the other hand, the women demonstrate moments of

awareness and even resistance to maternal and health norms, drawing on alternative discourses, embodied feelings, personal understandings of their body, and other women's experiences to trouble dominant health discourses and espouse a more reflexive subjectivity. This oscillation between the self-authored and the more reflexive subject demonstrates the fragmentation of the women's subject positions as they struggle with dominant expectations that they control weight, resist cravings and exercise regularly, while their personal experiences and embodied feelings seem to resist such recommendations.

The women's reproduction of dominant medical discourse surrounding health, obesity, and pregnancy maintains patriarchal power relations. By internalizing fetal health as paramount, and individual and moral responsibility for fetal health, medical dominance remains intact and the current social, gender, and political order go unchallenged. On a broader social level, this has a negative impact on women as it continues to deemphasize the social determinants of health and their more important impact compared to individual lifestyle factors (Raphael, 2003). Additionally, it ignores the dearth of work/family policies and programs aimed at helping women (and possible partners) raise a healthy family. Furthermore, casting pregnant women personally and morally responsible for fetal health may lead to other aspects of their lives, such as work, to be held accountable for any health complications during pregnancy. This leads to mother blame and can effectively relegate women back to the private sphere (Pollitt, 2008). This also has a negative impact on many of the individual participants who find it hard to reconcile external factors and embodied experiences with the dominant obesity and health discourses. Feeling that they might not be doing everything they can for their unborn baby, the women sometimes feel frustrated, worried, and anxious. Others express anger with a dominant medical discourse that ignores their own experiences during pregnancy.

Given such results, we would recommend that those in the health care sector pay particular attention to women's individual contexts rather than normalized and medicalized understandings of pregnancy (i.e., regimented calorie intake and weight control) that tend to blame women for their own "obesity" and for "risks" to the fetus. The women's frustration and confusion surrounding health recommendations may be greatly reduced if the diversity of pregnant women's experiences is embraced rather than stigmatized. Additionally, shifting policy and program focus to other aspects that affect the pregnant woman's and fetal health (e.g., paternal health, attitudes toward and representations of pregnant women, pregnant women's socioeconomic status and related life conditions) may decrease some of the pressure that pregnant women feel and the self-blame associated with pregnancy experiences (e.g., weight gain, cravings) and potential pregnancy-related health problems.

### **Final Thoughts**

In this article, we documented how a small group of women discursively construct their health during pregnancy in the context of the dominant obesity discourse. The women's constructions of pregnancy health emphasize fetal health and the pregnant woman's responsibility for and control over health, while constructions of embodied and personal experiences contradict this control. Through a poststructuralist discourse analysis we found that the women recite dominant medical, health, and obesity discourses emphasizing lifestyle factors, and maternal and moral responsibility for the fetus. Finally we have shown how these women adopt complex and at times conflicted subject positions as they simultaneously reproduce alternative (cultural, their own and other women's experiences) and dominant discourses surrounding pregnancy. Additionally, sometimes alternative discourses recited by the women

refute the dominant obesity discourse (i.e., refuting weight gain guidelines). However, it is important to emphasize that the women we spoke with consider themselves healthy and in relatively ‘risk free’ pregnancies. They are also able-bodied, white, heterosexual women. Given that health and obesity are racialized, ableist and heterosexist constructs, especially as they pertain to women (Rail, 2009, Rail & Lafrance, 2010; Saguy & Almeling, 2008), it would be important that future studies focus on women of differing races, ethnicities, abilities and gender orientations, and on those women with higher risk pregnancies. In locating the potential for resistance, we agree with Sawicki (1991) that we should continue to explore the “different ways in which women are being affected... the material conditions of their lives, their own descriptions of their needs, and of their experiences of pregnancy and childbirth” (p. 87). It is from these subjugated positions that further resistance and disruption of the dominant obesity and medicalized discourse during pregnancy become possible.

### References

- Bartky, S. L. (2003). Foucault, femininity, and the modernization of patriarchal power. In R. Weitz (Ed.), *The politics of women's bodies: Sexuality, appearance, and behaviour* (pp. 25-45). New York, NY: Oxford University Press.
- Boero, N. (2007). All the news that's fat to print: The American “obesity epidemic” and the media. *Qualitative Sociology*, 30(1), 41-60.
- Bondas, T. & Eriksson, K. (2001). Women's lived experiences of pregnancy: A tapestry of joy and suffering. *Qualitative Health Research*, 11, 824-840.
- Bordo, S. (1993). *Unbearable weight: Feminism, western culture, and the body*. Los Angeles, CA: University of California Press.

- Butler, J. (1997). *Excitable speech: A politics of the performative*. London: Routledge.
- Campos, P. Saguy, A., Ernsberger, P., Oliver, E., & Gaesser, G. (2006). The Epidemiology of Overweight and Obesity: Public Health Crisis or Moral Panic? *International Journal of Epidemiology*, 35(1), 55-60.
- Chavkin, W. (1992). Women and the fetus: The social construction of conflict. In C. Feinman (Ed.), *The criminalization of a woman's body* (pp. 193-202). New York, NY: Harrington Park Press.
- Clarke, A. E., Mamo, L., Fishman, J. R., Shim, J. K., & Fosket, J. R. (2003). Biomedicalization: Technoscientific transformations of health, illness, and U.S. biomedicine. *American Sociological Review*, 68, 161-194.
- Devine, C., Bove, C., & Olson, C. (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 & Medicine*, 50(4), 567-582.
- Evans, J., Rich, E., & Davies, B. (2004). The emperor's new clothes: Fat, thin and overweight. The social fabrication of risk and health. *Journal of Teaching Physical Education*, 23(4), 372-392.
- Fortin, S., Cyr, C., & Tremblay, M. (2005). The act of listening to the art of giving voice: Creative alternative practices in writing about health in dance. *Dance Research Journal*, 37(2), 11-24.
- Foucault, M. (1977). *Discipline & punish: The birthplace of the prison*. (A. Sheridan, Trans.) New York, NY: Vintage Books (original work published 1975).
- Foucault, M. (1978). *The history of sexuality: An introduction-vol. I*. (R. Hurley, Trans.) New York, NY: Vintage Books (original work published 1976).

- Foucault, M. (2003). The birth of biopolitics. In P. Rabinow and N. Rose (Eds.), *The essential Foucault* (pp. 338-350). New York: The New Press.
- Gard, M. & Wright, J. (2005). *The obesity epidemic: Science, morality, and ideology*. London, UK: Routledge.
- Haber, H. F. (1996). Foucault pumped: Body politics and the muscled woman. In S. J. Hekman (Ed.), *Feminist interpretations of Michel Foucault* (pp. 137-156). University Park, PA: The Pennsylvania State University Press.
- Jette, S. (2006). Fit for two? A critical discourse analysis of Oxygen fitness magazine. *Sociology of Sport Journal*, 23, 331-351.
- Jovanovic, L. (2001). What is so bad about a big baby? *Diabetes Care*, 24(8), 1317-1318.
- Kvale, S. & Brinkmann, S. (2009). *InterViews: Learning the craft of qualitative research interviewing* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage Publications.
- Kuhlmann, A. K., Dietz, P. M., Galavotti, C., & England, L. J. (2008). Weight management interventions for pregnant or postpartum women. *American Journal of Preventative Medicine*, 34(6), 523-527.
- Lane, K. (2008). The medical model of the body as a site of risk: A case study of childbirth. In C. Malacrida & J. Low (Eds.), *Sociology of the body: A reader* (pp. 157-164). London, UK: Oxford University Press.
- Lazarus, E. S. (1994). What do women want?: Issues of choice, control, and class in pregnancy and childbirth. *Medical Anthropology Quarterly*, 8(1), 25-46.
- Longhurst, R. (2001). *Bodies: Exploring Fluid Boundaries*. London, UK: Routledge.
- Lupton, D. (1999). Risk and the ontology of pregnant embodiment. In Lupton, D. (Ed.), *Risk and sociocultural theory: New directions and perspectives* (pp. 59-85). Cambridge, UK: Cambridge University Press.

- MacNeill, M., & Rail, G. (2010). The visions, voices and moves of young “Canadians”: Exploring diversity, subjectivity and cultural constructions of fitness and health. In J. Wright & D. Macdonald (Eds.), *Young people, physical activity and the everyday* (175-193). London and New York: Routledge.
- Markens, S., & Browner, C. H. (1997). Feeding the fetus: On interrogating the notion of maternal-fetal conflict. *Feminist Studies*, 23(2), 351-372.
- Martin, E. (1987). *The woman in the body: A cultural analysis of reproduction*. Boston, MA: Beacon Press.
- Mitchinson, W. (2002). *Giving birth in Canada: 1900-1950*. Toronto, ON: University of Toronto Press.
- Murray, S. (2007). Corporeal knowledges and deviant bodies: Perceiving the fat body. *Social Semiotics*, 17(3), 361-373.
- Oliver, E. (2005). *Fat politics: The real story behind America's obesity epidemic*. New York, NY: Oxford University Press.
- Orbach, S. (2006). Commentary: There is a public health crisis-it's not fat on the body but fat in the mind and the fat of profits. *International Journal of Epidemiology*, 35, 67-69.
- Polley, B., Wing, R., & Sims, C. (2002). Randomized controlled trial to prevent excessive weight gain in pregnant women. *International Journal of Obesity*, 26, 1494-1502.
- Pollitt, K. (2008). ‘Fetal rights’: A new assault on feminism. In C. Malacrida & J. Low (Eds.), *Sociology of the body: A reader* (pp. 183-188). London, UK: Oxford University Press.
- Rail, G., Holmes, D., & Murray, S.J. (2010). The politics of evidence on “domestic terrorists”: Obesity discourses and their effects. *Social Theory and Health*, 8(3), 259-279.
- Rail, G. (2009). Canadian youth's discursive construction of health in the context of

- obesity discourse. In J. Wright & V. Harwood (Eds.), *Biopolitics and the 'obesity epidemic': Governing bodies* (pp. 141-156). New York, NY: Routledge.
- Rail, G., & LaFrance, M. (2009). Confessions of the flesh and biopedagogies: Discursive constructions of obesity on Nip/Tuck. *Medical Humanities*, 35, 76-79.
- Raphael, D. (2003). Addressing the social determinants of health in Canada: Bridging the gap between research findings and public policy. *Policy Options*, March, 35- 44.
- Richardson, L. (1992). The consequences of poetic representation: Writing the other, rewriting the self. In C. Ellis & M. G. Flaherty (Eds.), *Investigating subjectivity: Research on lived experience* (pp. 125-140). Newbury Park, CA: Sage Publications.
- Root, R. & Browner, C. (2001). Practices of the pregnant self: Compliance with and resistance to prenatal norms. *Culture, Medicine and Psychiatry*, 25(2), 195-223.
- Rudolfsdottir, A. G. (2000). 'I am not a patient, and I am not a child': The institutionalization and experience of pregnancy. *Feminism & Psychology*, 10, 337-350.
- Ruhl, L. (1999). Liberal governance and prenatal care: Risk and regulation in pregnancy. *Economy and Society*, 28(1), 95-117.
- Saguy, A. C. & Almeling, R. (2008). Fat in the fire? Science, the news media, and the "obesity epidemic". *Sociological Forum*, 23(1), 56-83.
- Sawicki, J. (1991). *Disciplining Foucault: Feminism, power, and the body*. New York, NY: Routledge.
- Smith, S. A., Hulsey, T., & Goodnight, W. (2008). Effects of obesity on pregnancy. *JOGNN*, 37, 176-184.
- Sprague, J. (2005). *Feminist methodologies for critical researchers: Bridging differences*. Walnut Creek, CA: Lanham.

- Weedon, C. (1997). *Feminist practice and poststructuralist theory* (2<sup>nd</sup> ed.). Oxford, UK: Blackwell Publishing.
- Weir, L. (2006). *Pregnancy, risk and biopolitics: On the threshold of the living subject*. Oxon, UK: Routledge.
- Weissgerber, T., Wolfe, L., Davies, G., & Mottola, M. (2006). Exercise in the prevention and treatment of maternal-fetal disease: A review of the literature. *Applied Physiology, Nutrition, and Metabolism*, 31, 661-674.
- Wright, J. (1995). A feminist poststructuralist methodology for the study of gender construction in physical education: Description of a study. *Journal of Teaching in Physical Education*, 15, 1-24.
- Young, I. M. (1990). *On female body experience: "Throwing like a girl" and other essays*. London, UK: Oxford University Press.

**Chapter VI**

**“Silhouettes of a Pregnant Belly”:**

**Investigating Young Pregnant Women’s Discursive Constructions of the Body**

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### **Abstract**

In this article we draw on a feminist poststructuralist perspective to explore how young pregnant women discursively construct the pregnant body in the context of the dominant obesity discourse and other prevailing bodily discourses. Open-ended interviews were conducted with 15 pregnant young women between the ages of 18 and 28, from various socioeconomic and educational backgrounds in the Ottawa region. The narratives reveal that overall the women are interpellated by the dominant obesity discourse and other bodily discourses surrounding beauty, femininity, and heterosexuality. Paradoxically, they also recite contradictory and alternative discourses, resisting dominant bodily discourses. The women seem to constitute themselves as conflicted subjects simultaneously reproducing dominant and subversive discourses. This leads us to conclude with a discussion surrounding the need for more inclusive subject positions during pregnancy.

Key Words: Women, Pregnancy, The Body, Obesity, Feminism, Poststructuralism

## **“Silhouettes of a Pregnant Belly”:**

### **Investigating Young Pregnant Women’s Discursive Constructions of the Body**

Currently, women are expected to uphold a certain feminine ideal, that of the slim, tight, youthful body (Bartky, 2003; Bordo, 1993). Conversely, pregnancy has been considered a time when this surveillance is more relaxed. The pregnant body has been historically constructed as requiring increased rest and less vigorous activity, for fear of harming the mother and fetus (Mitchinson, 2002). Furthermore, Longhurst (2001) argues that, during pregnancy, women tend to orientate away from the public sphere and withdraw towards the private area of the home. Additionally, since the body is preparing to give birth to another life, many argue that it is constructed as functional rather than ornamental (Bailey, 2001; Longhurst, 2001; Seibold, 2003). Thus, as women transition to the pregnant body, there is lowered expectation to uphold the slender feminine ideal.

Most recently, there has been an increased expectation in the media to uphold an ideal feminine body during pregnancy, by retaining a certain (relatively slim) shape and size, and ‘bouncing back’ more quickly after giving birth (Dworkin & Wachs, 2004; Jette, 2006). More specifically, Dworkin and Wachs (2004) as well as Jette (2006) argue that exercise is being positioned as a means to keep the body in shape during pregnancy and ‘regain’ the pre-pregnancy body more quickly afterwards. Jette (2006) also posits that the pictures of models in pregnancy fitness magazines serve a panoptic function as they are toned and lean, showing “weight” only in the stomach area. Thus, women reading such magazines may feel pressure to emulate the models within their pages.

Concurrently, increasing medical literature is emphasizing ‘risks’ associated with obesity during pregnancy for the mother and fetus (Smith, Hulsey, & Goodnight, 2008; Siega-Riz,

Evenson, & Dole, 2004). This has led to weight, diet and exercise intervention strategies (Asbee et al., 2009; Kuhlmann, Dietz, Galavotti, & England, 2008). Such strategies are related to an increasing emphasis on weight and obesity in Western society where the ‘risks’ associated with ‘excess’ weight gain are stressed. Many scholars identified a dominant obesity discourse that equates slenderness with health, where weight control is emphasized as an individual matter of choice and will power (Gard & Wright, 2005; Oliver, 2005; Rail, 2009; Rail, Holmes & Murray, 2010; Rail & Lafrance, 2009). Others suggested that such discourse leads to the stigmatization of those who do not uphold the bodily norm (Campos, Saguy, Ernsberger, Oliver, & Gaesser, 2006; Gard & Wright, 2005; Murray, 2007; Oliver, 2005; Saguy & Almeling, 2008).

Feminist scholars have discussed at length the negative impact that rigid bodily expectations have on women as they can lead to disordered relationships with the body and lower quality of life (e.g., Bartky, 2003; Bordo, 1993; Orbach, 2006). Accordingly, some researchers raised concerns about possible and similar (negative) effects of an obesity discourse that qualifies the slim body as the ‘normal’ body (Gard & Wright, 2005; Murray, 2007). Others discussed the possible impact of a media emphasis that constructs the slim body as the “healthy and beautiful” body (Duncan, 1994; Eskes, Duncan, & Miller, 1998; Markula, 2001). Furthermore, Rice (1995) stressed the pressure this bodily ideal may put on women during pregnancy, leading to further anxiety about weight gain during pregnancy and dangerous weight control strategies (i.e., negatively impacting the psychological and physical health of both mother and fetus).

Therefore, the purpose of this article is to investigate young pregnant women’s constructions of their body in the context of the dominant obesity discourse and other bodily discourses (i.e., beauty, femininity, and heterosexuality) prevailing in North America. More specifically, we aim to provide a deeper understanding of whether young pregnant women are appropriating or resisting dominant discourses on the body and obesity, and how they constitute

their subjectivities within these available discourses. Furthermore, we wish to identify alternative subject positions and points of resistance, subsequently opening up new ways of reading weight, shape, and the body during pregnancy.

This paper will begin with an overview of the literature on pregnant women's constructions of the body. We will then outline our use of a feminist poststructuralist methodological and theoretical framework. Next we will provide the results of our thematic analysis in the format of diary entries (representing our participants' constructions of the body). We will then discuss our results in more depth and consider feminist poststructuralist understandings of the participants' bodily constructions in relation to dominant bodily discourses. Lastly, we will propose future directions for continued research.

### **Writings on the Pregnant Body**

Exploring pregnant women's images and representations of their body, some scholars found that they are reoriented away from the feminine slender norm (Bailey, 2001; Chang, Chao, & Kenney, 2006; Seibold, 2003). Chang, Chao and Kenney (2006) proposed that body changes and weight gain are understood as an indication of fetal growth and signs of a new role as mother. These authors suggest that the changing idea of the body — from ornamental to functional — may lead some women to feel comfortable with their body during pregnancy.

Simultaneously, other scholars argued that women are very aware of their bodily changes during pregnancy and that these changes invoke conflicting feelings regarding weight (Bailey, 2001; Bondas & Eriksson, 2001; Chang, Chao, & Kenney, 2006; Devine, Bove, & Olson, 2000; Earle, 2003; Johnson, Burrows, & Williamson, 2004; Wiles, 1994; Young, 1984). More specifically, many researchers discovered that a good fraction of women feel “horrible” about

their appearance and size during pregnancy. Devine, Bove and Olson (2000) as well as Wiles (1994) found that depending on women's weights before pregnancy, they felt more or less comfortable with weight gain — those being heavier feeling more at ease with their changing bodies during pregnancy. Johnson, Burrows and Williamson (2004) noted that “pregnancy was therefore used as a legitimate reason for gaining weight. However, this still had to be within acceptable boundaries” (p. 367). Gaining weight is perceived as acceptable; however, only to a certain point and in certain places. Earle (2003) discussed the various concerns that pregnant women have regarding weight, including when they will begin to look pregnant, where changes on their bodies will happen, and the ease of return to pre-pregnancy weight. The transitory nature of pregnancy also influences the comfort that some women feel with gaining weight. Bailey (2001), for instance, commented that some of the pregnant women she interviewed understood pregnancy as a temporary state and were therefore anxious about their changing bodies and fearful of trying to lose weight post-partum. Finally, a number of scholars observed a heightened anxiousness towards the body and weight gain during pregnancy (e.g., Earle, 2003; Johnson, Burrows, & Williamson, 2004).

In brief, there seems to be two very different sets of findings so far on women's experiences and representations of their body during pregnancy: some pointing to women being comfortable with their pregnant body and others suggesting the anxiety and disgust in relation to this body. All authors found a concern with weight among pregnant women but most conducted their study prior to North American societies waging their “war on obesity” (Rail, Holmes & Murray, 2010). In addition, although much research has looked at how women understand their experiences of pregnancy, little research has been done in a Canadian context (Mitchinson, 2002; Parry, 2006) and none, in Canada, looking specifically at discursive constructions of the body. The objective of the present study is to help fill such gaps.

### **Using a Feminist Poststructuralist Lense**

In our study, we favour a feminist poststructuralist approach (Rail, 2009; Weedon, 1997; Wright, 1995). We find Foucault's conceptualization of power useful in terms of its applicability to the body. Indeed, the work of Foucault can be used to analyze the influence of power on the body because it examines, "knowledge formations, and systems of power that regulate corporeal practices" (see Rail & Harvey, 1995, p. 165). Power is here understood as a localized, pervasive power that exerts influence at all levels. Foucault (1975/1977) has emphasized the regulatory form of disciplinary power as "the penetration of regulation into the smallest details of everyday life through the mediation of the complete hierarchy that assured the capillary functioning of power" (p. 198). In this article, we draw on other Foucauldian concepts important in the exercise of disciplinary power such as "surveillance," the "gaze," and the "docile body." Bartky (2003) has argued that disciplinary power acts to create docile feminine bodies that regulate themselves according to the feminine ideal. More specifically, notions of surveillance and the gaze lead women to self-regulate bodily practices, upholding their inferiority (Bartky, 2003; Bordo, 1993; Duncan, 1994; Eskes, Duncan, & Miller, 1998; Markula, 2001). Although, pregnant bodies may have been traditionally exempt from these practices, the increased targeting of pregnant women's bodily shape and size necessitates the use of such concepts to theorize the ways in which pregnant women may be impacted.

Our feminist poststructuralist perspective also posits that bodies are created through language. Language creates discourses that come to be seen as "truth" given their repetition and reaffirmation (Mills, 1997). However, discourses are always tenuous and fleeting since power relations are constantly changing, thus influencing and altering discourses and their place (e.g., central, marginal) within society. Consequently, discourses can uphold power relations, but also

act as a “starting point for an opposing strategy” (Foucault, 1976/1978, p. 101). Furthermore, Foucault (1977/1975) argues that power produces the subject through interpellation by certain discourses. An individual’s subjectivity is created in and through discourses interpellating him or her (Weedon, 1997). However, subjectivity is not stable or fixed, but rather “performative” (Butler, 1997), that is, occurring through actions already socially established. By deconstructing discourses and available subject positions, power structures are exposed, and spaces are created for new ways of understanding (the pregnant body, in the present case).

In this qualitative research, we used a feminist poststructuralist methodology. Feminist scholars argue that the goal of research is to advance the interests of their participants by challenging women’s oppression, questioning patriarchal power relations, and practically improving the conditions of women’s lives through research (Sprague, 2005). In addition, a feminist poststructuralist stance stresses the act of research as a joint process with the participant wherein meaning and knowledge are created (and not found) through interaction (Kvale & Brinkmann, 2009). Following from this position, narratives were constructed with the participants through open-ended ‘interViews.’ ‘InterViews’ were participant-centred but nevertheless understood as a journey between two people influencing each other and creating meaning together (Kvale & Brinkmann, 2009).

We conducted 15 interViews with young pregnant women between the ages of 18 and 28 in the Ottawa area. These women were recruited with the use of a snowball sampling method as well as communication with a local pre-natal program. InterViews were set up at a time and location of the women’s choice. Women freely consented to participating in the study and were able to drop out at anytime. The InterViews were tape-recorded and lasted between one and two hours. A guide helped to steer the interViews, but participants were encouraged to open up the conversation within the main themes of health, obesity, pregnancy, and the body. The

conversations were then transcribed verbatim, organized with the use of the NVIVO software, and analyzed using both thematic and feminist poststructuralist discourse analyses.

First, the thematic analysis involved the identification of themes within and between the women's narratives by regrouping text fragments according to semantic affinity. This allowed us to better understand young pregnant women's discursive constructions of the body as well as how their situational contexts interacted with their experiences and constructions.

Second, a feminist poststructuralist discourse analysis (Rail, 2009; Weedon, 1997; Wright, 1995) was used to elaborate on these constructions and identify the various discourses that were being appropriated, accommodated and/or resisted. Particular attention was given to the ways in which the participants constructed their subjectivities through available discourses on the body, obesity and pregnancy, and how they positioned themselves as subjects within such discourses.

### **From Discursive Constructions to Body Stories**

Since we understand the narratives from a poststructuralist perspective, we took this under consideration when deciding how to present the results of our analysis of the young pregnant women's discursive constructions of the body. We noted how the telling of lived experiences does not follow a linear path; instead it is messy and contradicts itself at every turn. Holstein and Gubrium (2005) write that "in practice, diverse articulations of discourse intersect, collide, and work against the construction of common or uniform subjects, agents, and social realities" (p. 498). We concur and wanted to portray the diverse articulations and the consequent contradictory subject positions of our study participants in a creative, evocative and accessible way.

We drew inspiration from previous scholars who helped form a movement of creative qualitative research — those who continue to push boundaries and question the methodologies and possible outcomes of research (Denzin, 2003; Richardson, 2002; Ellis & Bochner, 1992). These authors and many others experimented with the use of creative writing to portray the contradictory lived experiences of individuals. These creative writings, such as poems, short stories and performance pieces, provide new ways of envisioning the dissemination of research results. Through creative writing, we are not only able to show the paradox within the narratives, but also the emotional experiences of the women (Denzin, 2003; Richardson, 2002). In doing so, we may provide the participants themselves and their community of reference with elements that are emotional, provoking and providing “deeper” understandings of the phenomenon at hand. We followed in the steps of Fortin, Cyr and Tremblay (2005) who used a diary to showcase their results. Likewise, we created diary entries so they could be evocative, informative and readable (Kidd & Finlayson, 2009), hoping to infuse the text with subjectivity throughout, by connecting it with the innermost feelings of the participants. Like Madill and Hopper (2007), we created the diary using “the participants’ repeated points, underlying themes, and the sentences that summed up their meaning” (p. 47). Thus, the diary includes the words and emotions of the participants as well as interpretation on the part of the researchers. The diary entries make explicit the five themes that emerged for our discourse analysis of the young pregnant women’s constructions of the body during pregnancy: (a) un/controllable; (b) a condition that sometimes permits a break from the feminine ideal; (c) not fat; (d) beautiful yet sometimes alien; and (e) (possibly) leaving permanent signs. As feminist researchers, reciprocity and trustworthiness are important aspects of our research process (Jansen & Davis, 1998). In order to give the participants the opportunity to more fully participate in the research and to verify the trustworthiness of our results the diary was sent to the women electronically. Three of the women responded, all with positive feedback,

commenting that the diary represented their own or another woman's constructions of her pregnant body. Small changes were made to the diary itself, but overall we did not need to adjust our analysis.

To provide a deeper understanding of the women's discursive constructions, it is important to clarify their situational contexts. The participants come from diverse backgrounds, as they vary in their socioeconomic, educational, marital, and employment status. They differ in trimester, and most are on their first pregnancy, while one is on her second and one on her third pregnancy. They describe their body types in diverse ways, such as "athletic," "curvy," "small," "fat," and "obese." Lastly, they vary in their description of body satisfaction; about one third of the women have dieted before and one woman identifies herself as bulimic.

***June 23, 2009 (14 wks pregnant)***

*I still can't believe I'm pregnant! But when will I start to look pregnant? I mean, I'm worried my clothes are getting tighter because I'm eating too much. I need to watch what I eat... I've seen other women who ate a lot during their pregnancy, and even afterwards they're still huge! But, it is normal to gain weight during pregnancy, and each woman is different. Your body knows what it's doing, you need to listen to it. It's pointless worrying. Regardless, my body is going to do what it wants. It's frustrating though, and I've heard it just gets worse as your body is changing and stretching, and your clothes aren't fitting. I just want some feeling of normalcy throughout. I don't want to lose the body I feel comfortable with.*

***August 19, 2009 (22 wks pregnant)***

*I've decided to dress for comfort now. Who cares how I look? I'm not trying to impress anyone. I'm pregnant! But yesterday, I felt horrible. We got pictures back from the California trip. I want*

*to be comfortable, but I looked like a COW in my dress compared to everyone else! But I can't be concerned about my body during pregnancy, and right now I'm really enjoying my big belly. I mean, it definitely feels like a nice vacation from having to worry about that little beer gut that normally bothers me so much. I just don't want to gain too much weight! It already hurts to look down at that scale and see the numbers I'm seeing now. I've never been this big before. I'll be pushing 170, and in my head, the way I've been conditioned, it's scary! But, pregnancy means weight gain and I should be happy... At least I haven't gained a bunch in my face and arms.*

***Sept. 25, 2009 (27 wks pregnant)***

*I AM SO ANGRY! I couldn't believe what my boss said to me today. Kelly, one of my other coworkers gained a lot of weight all over when she was pregnant, and he said he hopes I don't turn out like her. Who does he think he is? Pregnant women are gaining for a reason! We're not fat! There's a living growing being inside, pushing out our bellies, affecting our entire body. How are we supposed to feel? I'm doing the best I can. I'm eating properly and exercising. People expect us to be these silhouettes of pregnant women, just a belly. It makes me so mad!*

***October 15, 2009 (31 wks pregnant)***

*I've been really admiring the shape that my pregnant body is taking. It puts me in complete awe of what women are capable of. Now, it's just afterwards that worries me sometimes. I promised myself that once this baby is out, I'm going to be in a bikini by the summer. But I'm scared. I mean, money and time are going to be tight afterwards. How am I going to have the time to cook healthy meals and go to the gym? I'm nervous about my stretch marks too. How can you look sexy with stretch marks all over your stomach? Hopefully the creams I've been using will do something. But I am also really proud of myself and, in the end, everything I'm going through is*

*for my baby. I know she'll make it all worthwhile. Going through this incredible ordeal, there are bound to be battle scars!*

### **Bodily Contradictions Explored**

Bringing about social change requires the narrator's story, but also the identification of underlying power structures and dominant discourses that pervades these stories. Chase (2005) emphasizes that, "When researchers' interpretive strategies reveal the stranglehold of oppressive metanarratives, they help to open up possibilities for social change" (p. 688). She goes on to argue that this is only possible with "the researcher's explication of how the narrator's story is constrained by, and strains against, the mediating aspects of culture" (p. 688). While the presentational strategy of the diary displays the messiness and paradox inherent in the women's constructions of their pregnant body, a poststructuralist analysis illuminates how they navigate dominant or resistant discourses surrounding the body. In the following paragraphs, we summarize the results of our feminist poststructuralist analysis and further explore the women's discursive constructions of the pregnant body identified in the previous section.

#### ***The Pregnant Body is... Un/Controllable***

The body is traditionally constructed as controllable, seen as a modernist body under the control of a rational, autonomous mind (Shilling, 1993). Dworkin and Wachs (2004) as well as Jette (2006) have also argued that the pregnant body is increasingly portrayed, by media and medical spheres, as controllable through exercise and nutrition. Parallel elements are also evident in the obesity discourse wherein lifestyle is presented as something an individual may control,

thus providing this individual with ways to control his or her weight (Boero, 2007; Saguy & Almeling, 2008). The women in our study appropriate the obesity discourse as well as modernist understandings of the body. This is most evident when they mention a woman's food intake or lack of exercise as causes of her excess weight gain during pregnancy, and when they suggest that they do not worry about their weight gain during pregnancy as long as they keep exercising and controlling cravings.

Contradictorily, some scholars argue that pregnancy defies modernist understandings of the body and is characterized as a "series of biological transitions over which the mother-to-be has little control" (Warren & Brewis, 2004, p. 222). Indeed, our participants do simultaneously recite this alternative discourse of the uncontrollable pregnant body. On many occasions they mention that their body is going to do what it wants, and that listening to their body is important during pregnancy, including when to rest and eat. Some also discuss how their body is going to gain how much it wants, where it wants, regardless of what they do. Thus, they do appropriate aspects of the dominant obesity discourse, but at other times resist constructions of a controllable body during pregnancy.

***The Pregnant Body is... a Condition that Sometimes Permits a Break from the Feminine Ideal***

As mentioned earlier, expectations to uphold the feminine ideal may be relaxed during pregnancy. Thus, the ability to give up this control may be a welcomed rest from constant corporeal surveillance (Warren & Brewis, 2004). However, our narratives point to conflicted feelings about this 'break' from conventional femininity. On the one hand, the women do resist the overall view that they need to uphold a certain appearance, and many mention that this is a

time when they do not stress as much about how they look. They discuss dressing for themselves instead of others and wearing clothes in which they feel comfortable.

On the other hand, many of the women also mention feeling nervous about losing the body with which they are comfortable. Moreover, although some of the women display awareness of the social construction of their 'normal' body, this does not prevent them from feeling anxious about losing that body. The women worry about how much weight they are going to gain and where they will gain it. Similar to Earle's (2003) findings, our participants stress that it is fine to gain weight in the "belly" and around the "hips and butt", but express more concern about the arms or face. The women seem interpellated by dominant discourse in the media that emphasize the 'ideal' pregnant body as one that only gains a small amount in the abdominal area (Jette, 2006), and the obesity discourse that emphasizes the control individuals (including pregnant women) have over their bodies (Gard & Wright, 2005; Saguy & Almeling, 2008).

The women recite dominant discourses of control and beauty that emphasize bodily surveillance during pregnancy and point to the expectation that women maintain a specific body even while pregnant. Conversely, the women also recite resistant discourses whereby they feel free to enjoy their bodies and forget about the ideal feminine form. Therefore, they reproduce dominant discourses while also turning to alternative discourse to understand their body during pregnancy.

### ***The Pregnant Body is... Not Fat!***

Although, some scholars (Warren & Brewis, 2004; Young, 1984) argue that societal expectations to uphold the feminine norm during pregnancy may be relaxed, this may not always be the case. The women discuss the increased physical presence of their body, and an external gaze that renders them more aware of their body. They also reveal comments by outsiders that

reproduce discourses of beauty and femininity during pregnancy, such as how much and where pregnant women should gain weight, and derogatory comments towards pregnant women who gain “too much” or who are “fat.” The women discuss awareness of the public scrutiny over their pregnant body, and they resist the idea that this gives outsiders excuses to judge them.

Given the negative views of excess weight gain as deviating from the feminine ideal, it is not unexpected that the women we spoke with are quite negative towards external comments about pregnant women being fat. Dworkin and Wachs (2004) write that “flesh or fat on the body has been framed as a signifier of excessiveness, being out of control, a devaluation of the feminine, and failed individual morality needing earthly discipline” (p. 611). The women are quick to point out that pregnant women are pregnant and not fat. There is a difference between their bodies and those of women who are not pregnant since they are “doing it for a reason.” The fear of looking fat and not pregnant is also discussed when the women talk about their own bodies. Early in pregnancy, some women are anxious to begin to look pregnant instead of fat. This is similar to Earle’s (2003) findings where women are quick to make the distinction between their body and fat bodies. Thus, the women continue to reproduce discourses of traditional beauty and stigmatization of the fat body.

At the same time they also resist the construction of the pregnant body as solely a “belly”, and defend pregnant women whose size and shape deviate from this norm. Therefore, while at other times they recite elements of dominant discourses, expressing the control they have over weight gain, and needing to maintain a certain feminine body during pregnancy, they become much more resistant to these discourses when confronted by outsiders accusing pregnant women of being “fat” and needing to be a certain size or shape. In this way the women simultaneously appropriate and resist dominant discourses of bodily control, femininity, and beauty during pregnancy.

### *The Pregnant Body is... Beautiful yet Sometimes Alien*

Dominant and resistant discourses are apparent when many of the women construct their pregnant body as beautiful and wonderful in its own right. They stress that carrying another life is an amazing experience, one that gives them a sense of empowerment. Therefore, the women uphold discourses surrounding traditional femininity, since pregnancy and motherhood are constructed as valued feminine accomplishments in Western society (Rudolfsdottir, 2000). However, the women simultaneously resist discourses surrounding the slim, tight, feminine body. Instead of the skinny, toned, petite, female form, they construct their larger, fleshier bodies as beautiful and amazing. Furthermore, many of them discuss how they admire their bodies during pregnancy more than before, enjoying the changing shape. Similarly, Seibold (2003) found that some of the women in her study expected and even enjoyed the bodily changes that accompanied pregnancy.

Reproduction of dominant discourses of beauty and femininity (as the slim body) are also apparent. The women, at times, construct their body as something foreign and uncomfortable. This supports previous authors who found that women's narratives supported constructions of an ugly and alien body during pregnancy because of its divergence from the feminine ideal (Greer, 1984; Young, 1984). Thus, that same body from which women may garner empowerment because of its divergence from the 'norm,' may at times also cause frustration and anxiety because of that same deviation. Longhurst (2001) goes on to argue that, "there is nothing intrinsic to the biological formations of pregnancy that requires a loathing of pregnant embodiment" (p. 55). Thus, this loathing of the pregnant body is socially constructed, and the strength of this construction is seen in the continual tension between the alien, uncomfortable body and the empowered, beautiful body.

### ***The Pregnant Body is... (Possibly) Leaving Permanent Signs***

Discourses of femininity and bodily control are increasingly emphasized during pregnancy to control the body post-pregnancy body (Dworkin & Wachs, 2004; Jette, 2006). Similarly to other scholarly findings, some of our participants worry during pregnancy about regaining their pre-pregnancy body after giving birth (Chang, Chao, & Kenney, 2006; Earle, 2003). Additionally, many of the participants are concerned about body changes that are counter to the feminine ideal such as stretch marks, varicose veins, and excess skin. Dominant discourses of obesity and bodily control are reproduced as these changes are constructed as possibly controllable during pregnancy by exercising, controlling calories, and not gaining ‘too much’ weight. Therefore, tension is again apparent between alternative discourses (i.e., the uncontrollable and natural body), and dominant discourses that emphasize reducing and controlling the effects of pregnancy.

Related to discourses of bodily control, the women also reproduce discourses of consumption. Featherstone (1982) argues that consumer culture presents body maintenance as necessary to uphold an acceptable appearance. Thus, through continued consumerism, individuals can ‘perform’ appropriately in society. The women mention product consumption when discussing actions they are taking or planning to take to “get their body back” and maintain an acceptable appearance. For example, certain foods, gym passes, fitness equipment, and creams are discussed as ways to increase chances of “bouncing back.” Self-surveillance over the pregnant body is expected if one is to be (re)accepted in society after pregnancy. Furthermore, their anxiety is connected to worries about possibly not having enough time between working and caring for their newborn. In addition, women of lower socioeconomic status mention the difficulty of affording gym passes, fitness equipment, and healthy food. This is troubling given

that the media assumes individuals are middle class, and can afford fitness goods and services or buy off their shift of housework (Dworkin & Wachs, 2004).

Discourses of heterosexuality are upheld in various discussions of wanting to maintain a certain 'attractive' body afterwards in order to attract or keep a male partner. Most women are aware that "getting their body back" is a societal (male) expectation; however, feeling this pressure to conform, they accommodate to such ideals. Some of the women worry about being able to find a partner if they do not regain their body, supporting Dworkin and Wachs' (2004) assertion that the media hint at the body being regained for husbands/men. This leads many women to feel anxious about bodily changes and possible permanent effects. Thus, goals of erasing signs of pregnancy and returning to pre-pregnancy form are paramount, given external expectations to return to the feminine ideal as quickly as possible.

However, the possible permanence of changes during pregnancy are not always approached with anxiety and frustration. Many times, the women resist discourses of beauty and femininity. They discuss not caring about trying to get their bodies back and that the permanent changes associated with pregnancy are worth it. Additionally, some women recite alternative discourse when they discuss the effects of pregnancy with pride. This is most strongly displayed when one woman constructs stretch marks as "battle scars." The re-signification of the effects of pregnancy from symbols of bodily lack and ugliness, to those of accomplishment and strength provide a strong alternative reading of the physical changes during pregnancy.

### **The Conflicted and Anxious Subject**

It is apparent that our participants draw simultaneously on contradictory (dominant and subversive) discourses in constructing their pregnant body, apparently leading them to conflicted

emotional experiences. Rather than acknowledging the different experiences that women have of their bodies, media and medical discourse are increasingly dichotomizing the pregnant body between that which is controllable and the proper weight and shape, and that which is out of control and transgressing proper physical boundaries. Binaries are present to construct the pregnant body either as sexual or asexual, ornamental or functional, controllable or uncontrollable, beautiful or alien.

Creating stories is one way to break down binaries and display the inconsistencies and overlaps within discourse (Davies, 1992). These binaries overlap and contradict each other within these women's narratives. The diary entries depict the struggles that pregnant women face with respect to their changing bodies, and the emotions inherent within such struggles. At once feeling proud, accomplished, happy and amazed, they are also frustrated, anxious and worried. Thus, throughout pregnancy, their bodies provide them with joy and wonder, but also concern and disappointment. Emotional responses are related to subjectivity; therefore, available subject positions need to be opened up to represent the complex and varied experiences that pregnant women have of their bodies, through the changing of dominant discourse and bringing to the forefront more subversive discourses. Furthermore, despite the increased presence of the pregnant body in the public sphere and despite the idea that holding this body to ideal feminine standards may resist the asexualization of the pregnant woman, we would argue that re-inscribing her body to the very narrow limits of the ideal feminine form serve only to continually constrain her. Without transformation, constructions of 'ideal' and 'acceptable' pregnant bodies will remain elusive for many women; thus, leading to continued anxious and conflicted subject positions.

### **A Need for More Conversations**

Our article hopefully contributes to a better understanding of young pregnant women's discursive constructions of the pregnant body and provides a first exploration of pregnancy within a discursive field where the obesity discourse dominates. Our study included a small group of diverse pregnant women but did not focus on those women going into pregnancy already categorized as 'overweight' or 'obese' or on those women coming from marginalized ethnic or racial communities. Although previous scholars discuss an increased acceptance of the body during pregnancy by 'overweight' and 'obese' women (Devine, Bove, & Olson, 2000; Wiles, 1994), the ever-increasing targeting and stigmatization of pregnant women identified as 'overweight' and 'obese' by popular and medical discourses may be changing this. Additionally, women of colour may be 'doubly' affected as they are increasingly stigmatized through the dominant obesity discourse (Azzarito, 2009; Saguy & Almeling, 2008). More specifically, Saguy and Almeling (2008) found that newspaper articles often racialize discussions on obesity by pointing out higher obesity rates among racialized groups and blaming those on simplistic understandings of "unhealthy cultures" or of cultural preferences for larger female bodies among African Americans. Therefore, pregnant women who are both 'obese' and of racial minority may be under increased scrutiny by both medical specialists and Western culture generally. Furthermore, discourses of obesity, beauty, and femininity discussed in this article are imbricated on ideas of whiteness (Dworkin & Wachs, 2004; Saguy & Almeling, 2008) and it is these racialized discourses that are appropriated by the participants in this study. Understanding ethnically and racially marginalized women's constructions of their body and the discourses that inform such discourses would thus be an important next step. Bringing to the forefront the experiences of women directly targeted by these interventions would provide a greater

understanding of their subject positions within dominant and alternative bodily discourses. In turn, this may continue to provide additional argument against normalized and constrained constructions of pregnancy, weight, shape, and beauty, leading to more inclusive representations of the pregnant body.

### References

- Asbee, S., Jenkins, T., Butler, J., White, J., Elliot, M., & Rutledge, A. (2009). Preventing excessive weight gain during pregnancy through dietary and lifestyle counseling: A randomized control trial. *Obstetrics & Gynecology*, *113*(2), 305-312.
- Azzarito, L. (2009). The rise of the corporate curriculum: Fatness, fitness, and whiteness. In J. Wright & V. Harwood (Eds.), *Biopolitics and the 'obesity epidemic': Governing bodies* (pp. 183-196). New York, NY: Routledge.
- Bailey, L. (2001). Gender shows: First-time mothers and embodied selves. *Gender and Society*, *15*(1), 110-129.
- Bartky, S. L. (2003). Foucault, femininity, and the modernization of patriarchal power. In R. Weitz (Ed.), *The politics of women's bodies: Sexuality, appearance, and behaviour* (pp. 25-45). New York, NY: Oxford University Press.
- Boero, N. (2007). All the news that's fat to print: The American "obesity epidemic" and the media. *Qualitative Sociology*, *30*(1), 41-60.
- Bondas, T. & Eriksson, K. (2001). Women's lived experiences of pregnancy: A tapestry of joy and suffering. *Qualitative Health Research*, *11*, 824-840.
- Bordo, S. (1993). *Unbearable weight: Feminism, western culture, and the body*. Los Angeles, CA: University of California Press.

- Butler, J. (1997). *Excitable speech: A politics of the performative*. London: Routledge.
- Campos, P., Saguy, A., Ernsberger, P., Oliver, E., & Gaesser, G. (2006). The Epidemiology of Overweight and Obesity: Public Health Crisis or Moral Panic? *International Journal of Epidemiology*, 35(1), 55-60.
- Chang, C., Chao, Y., & Kenney, N. J. (2006). I am a woman and I'm pregnant: Body image of women in Taiwan during the third trimester of pregnancy. *Birth*, 33(2), 147-153.
- Chase, S. E. (2005). Narrative inquiry: Multiple lenses, approaches, voices. In N. K. Denzin & Y. Lincoln (Eds.), *The sage handbook of qualitative research* (3<sup>rd</sup> ed.) (pp. 651-680). Thousand Oaks, CA: Sage.
- Davies, B. (1992). Women's subjectivity and feminist stories. In C. Ellis & M. G. Flaherty (Eds.), *Investigating subjectivity: Research on lived experience* (pp. 53- 78). Newbury Park, CA: Sage.
- Denzin, N. K. (2003). *Performance ethnography: Critical pedagogy and the politics of culture*. Thousand Oaks, CA: Sage Publications Ltd.
- Devine, C., Bove, C., & Olson, C. (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 & Medicine*, 50(4), 567-582.
- Duncan, M. C. (1994). The politics of women's body images and practices: Foucault, the panopticon, and Shape magazine. *Journal of Sport & Social Issues*, 18(1), 48-65.
- Dworkin, S. L. & Wachs, F. L. (2004). "Getting your body back" Postindustrial fit motherhood in Shape Fit Pregnancy magazine. *Gender & Society*, 18(5), 610-624.
- Earle, S. (2003). 'Bumps and boobs': Fatness and women's experiences of pregnancy. *Women's Studies International Forum*, 26(3), 245-252.

- Ellis, C. & Bochner, A. P. (1992). Telling and performing personal stories: The constraints of choice in abortion. In C. Ellis & M. G. Flaherty (Eds.), *Investigating subjectivity: Research on lived experience* (pp. 79-101). Newbury Park, CA: Sage.
- Eskes, T. B., Duncan, M. C., & Miller, E. M. (1998). The discourse of empowerment: Foucault, Marcuse, and women's fitness texts. *Journal of Sport & Social Issues*, 22(3), 317-344.
- Featherstone, M. (1982). The body in consumer culture. *Theory, Culture & Society*, 1(2), 18-33.
- Fortin, S., Cyr, C., and Tremblay, M. (2005). The act of listening to the art of giving voice: Creative alternative practices in writing about health in dance. *Dance Research Journal*, 37(2), 11-24.
- Foucault, M. (1977). *Discipline & punish: The birthplace of the prison*. (A. Sheridan, Trans.) New York, NY: Vintage Books (original work published 1975).
- Foucault, M. (1978). *The history of sexuality: An introduction-vol. I*. (R. Hurley, Trans.) New York, NY: Vintage Books (original work published 1976).
- Gard, M. & Wright, J. (2005). *The obesity epidemic: Science, morality, and ideology*. London, UK: Routledge.
- Greer, G. (1984). *Sex and destiny: The politics of human fertility*. London, UK: Secker & Warburg.
- Holstein, J. A. & Gubrium, J. F. (2005). Interpretive practice & social action. In N. K. Denzin & Y. Lincoln (Eds.), *The sage handbook of qualitative research* (3<sup>rd</sup> ed.) (pp. 483-506). Thousand Oaks, CA: Sage Publications, Inc.
- Jansen, G. & Davis, D. (1998). Honouring voice and visibility: Sensitive-topic research and feminist interpretive inquiry. *Affilia Journal of Women and Social Work*, 13(3), 289-312.
- Jette, S. (2006). Fit for two? A critical discourse analysis of Oxygen fitness magazine. *Sociology of Sport Journal*, 23, 331-351.

- Johnson, S., Burrows, A., & Williamson, I. (2004). 'Does my bump look big in this?' The meaning of bodily change for first-time mothers-to-be. *Journal of Health Psychology, 9*, 361-374.
- Kidd, J. & Finlayson, M. (2009). When needs must: Interpreting autoethnographical stories. *Qualitative Inquiry, 15*(6), 980-995.
- Kvale, S. & Brinkmann, S. (2009). *InterViews: Learning the craft of qualitative research interviewing* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage.
- Kuhlmann, A. K., Dietz, P. M., Galavotti, C., & England, L. J. (2008). Weight management interventions for pregnant or postpartum women. *American Journal of Preventative Medicine, 34*(6), 523-527.
- Longhurst, R. (2001). *Bodies: Exploring Fluid Boundaries*. London, UK: Routledge.
- Madill, T. F. & Hopper, L. (2007). The best of the best discourse on health: Poetic insights on how professional sport socializes a family of men into hegemonic masculinity and physical inactivity. *American Journal of Men's Health, 1*(44), 44-59.
- Markula, P. (2001). Beyond the perfect body: Women's body image distortion in fitness Magazine discourse. *Journal of Sport & Social Issues, 25*(2), 158-179.
- Mills, S. (1997). *The new critical idiom*. London: Routledge.
- Mitchinson, W. (2002). *Giving birth in Canada: 1900-1950*. Toronto, ON: University of Toronto Press.
- Murray, S. (2007). Corporeal knowledges and deviant bodies: Perceiving the fat body. *Social Semiotics, 17*(3), 361-373.
- Oliver, E. (2005). *Fat politics: The real story behind America's obesity epidemic*. New York, NY: Oxford University Press.

- Orbach, S. (2006). Commentary: There is a public health crisis-it's not fat on the body but fat in the mind and the fat of profits. *International Journal of Epidemiology*, 35, 67-69.
- Parry, D. C. (2006). Women's lived experiences with pregnancy and midwifery in a medicalized and fetocentric context: Six short stories. *Qualitative Inquiry*, 12(3), 459-471.
- Polley, B., Wing, R., & Sims, C. (2002). Randomized controlled trial to prevent excessive weight gain in pregnant women. *International Journal of Obesity*, 26, 1494-1502.
- Rail, G., Holmes, D., & Murray, S.J. (2010). The politics of evidence on "domestic terrorists": Obesity discourses and their effects. *Social Theory and Health*, 8(3), 259-279.
- Rail, G., & Lafrance, M. (2009). Confessions of the flesh and biopedagogies: Discursive constructions of obesity on Nip/Tuck. *Medical Humanities*, 35, 76-79.
- Rail, G. (2009). Canadian youth's discursive construction of health in the context of obesity discourse. In J. Wright & V. Harwood (Eds.), *Biopolitics and the 'obesity epidemic': Governing bodies* (pp. 141-156). New York, NY: Routledge.
- Rail, G. & Harvey, J. (1995). Body at work: Michel Foucault and the sociology of sport. *Sociology of Sport Journal*, 12, 164-179.
- Rice, C. (1995). *Promoting Healthy Body Image: A guide for program planners*. Toronto, ON, Canada: Ontario Ministry of Health, Best Start Community Action for Healthy Babies.
- Richardson, L. (2002). Poetic representation of interviews. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research: Context & method* (pp. 877- 892). Thousand Oaks, CA: Sage.
- Saguy, A. C. & Almeling, R. (2008). Fat in the fire? Science, the news media, and the "obesity epidemic". *Sociological Forum*, 23(1), 56-83.
- Seibold, C. (2003). Young single women's experiences of pregnancy, adjustment, decision-making and ongoing identity construction. *Midwifery*, 20, 171-180.

- Seiga-Riz, A. M., Evenson, K. R., & Dole, N. (2004). Pregnancy-related weight gain-A link to obesity? *Nutrition Reviews*, 62(7), S105-S111.
- Shilling, C. (1993). *The body and social theory*. London, UK: Sage.
- Smith, S. A., Hulsey, T. & Goodnight, W. (2008). Effects of obesity on pregnancy. *JOGNN*, 37, 176-184.
- Sprague, J. (2005). *Feminist methodologies for critical researchers: Bridging differences*. Walnut Creek, CA : Lanham.
- Warren, S. & Brewis, J. (2004). Matter over mind? Examining the experience of pregnancy. *Sociology*, 38(2), 219-236.
- Weedon, C. (1997). *Feminist practice and poststructuralist theory* (2<sup>nd</sup> ed.). Oxford, UK: Blackwell.
- Wiles, R. (1994). 'I'm not fat, I'm pregnant': The impact of pregnancy on fat women's body image. In Sue Wilkinson, & Celia Kitzinger (Eds.), *Women and health: Feminist perspectives* (pp. 33–48). London: Taylor and Francis.
- Wright, J. (1995). A feminist poststructuralist methodology for the study of gender construction in physical education: Description of a study. *Journal of Teaching in Physical Education*, 15, 1-24.
- Young, I. M. (1984). Pregnant embodiment: Subjectivity and alienation. *The Journal of Medicine and Philosophy*, 9, 45-62.

## CHAPTER VII

### CONCLUSION

Through this research, it is clear that the dominant obesity discourse disciplines the pregnant body, as the women are interpellated by discourses of individual control and moral responsibility for the body and health. More specifically, biopower acts to discipline the pregnant body through the creation of docile pregnant bodies that have internalized normalizing rules around bodily health practices (gaining the right amount) and thus protect the health of the population (Jette, 2006). Those women who do not uphold these practices -- by gaining too much weight or being obese before and during pregnancy -- are seen to threaten the health and vitality of the nation (e.g., 'breeding obesity'). In relation to this, the women discuss self-surveillance over their pregnant bodies through lifestyle practices (nutrition, moderate exercise) and the search for expert advice to reduce risks and provide the best environment for the growing fetus.

The obesity discourse also upholds discourses of beauty and femininity by focusing on the slim and toned body as being inherently healthy and beautiful. Pregnant women who make themselves the subjects of this discourse are thus disciplined to maintain a body that only gains a small amount in the abdominal area. Since for most women this objective is unattainable, the obesity discourse feeds their anxieties during pregnancy by emphasizing the 'risks' to fetal health and the mother's personal responsibility for such 'risks.' The participants display worry and anger regarding expectations placed on them to uphold fetal health as well as occasional anxiety and frustration with their changing pregnant bodies. In general, the dominant obesity discourse within which the participants position themselves is intricately related to other discourses surrounding health, the body, and pregnancy that maintain the current gender, social and cultural

order and de-emphasize structural and social barriers to health (Azzarito, 2009; Dworkin & Wachs, 2009; Saguy & Almeling, 2008).

But the women who took part in the present study do not constitute their subjectivities solely within the dominant obesity discourse: as both articles in this thesis attest, they recite alternative and at times resistant discourses as well. These women discuss alternative individual and cultural experiences that resist the dominant obesity discourse (e.g., lack of control over the pregnant body, external influences over health). The contradictory and conflicted subjectivities of the participants are constituted through a complex amalgam of competing discourses.

Given such results, I would recommend that those in the health care sector pay particular attention to women's individual contexts rather than normalized understandings of pregnancy (i.e., regimented calorie intake and weight control) that tend to blame women for their own "obesity" and increase pressure to be only a 'belly' during pregnancy. Shifting policy and program focus to other aspects that affect the pregnant woman's body and maternal and fetal health (e.g., attitudes toward and representations of pregnant women, pregnant women's socioeconomic status and related life conditions) may decrease some of the pressure that pregnant women feel to uphold a certain shape and size as well as the self-blame associated with pregnancy experiences (e.g., weight gain, cravings).

Finally, without the dissemination of these results any changes to current understandings of pregnancy, health, obesity and the pregnant body remain impossible; therefore, I plan to share this research with the community in a variety of ways. Firstly, both of the articles in this thesis have been submitted to journals read by individuals in the health care sector. Secondly, the articles, once revised and published, will be sent electronically to local organizations that provide programming for pregnant women in the Ottawa area, along with a brief letter specifying the main recommendations stemming from my study. Thirdly, a copy of the articles will also be sent

electronically to each of the participants. By sharing the results from this thesis, it may be a first step to disrupting the status quo and bringing about new ways to understand pregnancy and the pregnant body.

**PART THREE:**  
**STATEMENT OF CONTRIBUTORS, REFERENCES AND APPENDICES**

**CHAPTER VII**  
**STATEMENT OF CONTRIBUTORS**

September 21, 2010

To whom it may concern:

The present statement is to confirm that this thesis is the original work of Emma A. Harper. Emma A. Harper contributed to this thesis by doing the original research (i.e., data collection, data analysis, writing of results), and also wrote the two articles (Chapter V and VI). Geneviève Rail contributed by providing guidance and support throughout the process. She also gave editorial suggestions for both articles and thesis. It is important to note that this thesis and both articles are part of a larger project funded by SSHRC and lead by Geneviève Rail. The larger project is entitled, “Young women’s discursive constructions of health and the body in the context of obesity discourses and biopedagogies” (2008-2011).

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## REFERENCES

- Annis, N.M., Cash, T.F., & Hrabosky, J.I. (2004). Body image and psychosocial differences among stable average weight, currently overweight, and formerly overweight women: The role of stigmatizing experiences, *Body Image, 1*, 155–167.
- Asbee, S., Jenkins, T., Butler, J., White, J., Elliot, M., & Rutledge, A. (2009). Preventing excessive weight gain during pregnancy through dietary and lifestyle counseling: A randomized control trial. *Obstetrics & Gynecology, 113*(2), 305-312.
- Azzarito, L. (2009). The rise of the corporate curriculum: Fatness, fitness, and whiteness. In J. Wright & V. Harwood (Eds.), *Biopolitics and the 'obesity epidemic': Governing bodies* (pp. 183-196). New York, NY: Routledge.
- Baeten, J., Bukusi, E., & Lambe, M. (2001). Pregnancy complications and outcomes among overweight and obese nulliparous women, *American Journal of Public Health, 91* (3), 436-440.
- Bailey, L. (2001). Gender shows: First-time mothers and embodied selves. *Gender and Society, 15*(1), 110-129.
- Bartky, S. L. (2003). Foucault, femininity, and the modernization of patriarchal power. In R. Weitz (Ed.), *The politics of women's bodies: Sexuality, appearance, and behaviour* (pp. 25-45). New York: Oxford University Press.
- Bevir, M. (1999). Foucault and critique: Deploying agency against autonomy. *Political Theory, 27*, 65-84.
- Boero, N. (2007). All the news that's fat to print: The American "obesity epidemic" and the media. *Qualitative Sociology, 30*(1), 41-60.

- Bondas, T. & Eriksson, K. (2001). Women's lived experiences of pregnancy: A tapestry of joy and suffering. *Qualitative Health Research, 11*, 824-840.
- Bordo, S. (1993). *Unbearable weight: Feminism, western culture, and the body*. Los Angeles: University of California Press.
- Browne, K. (2003). Snowball sampling: Using social networks to research non heterosexual women. *International Journal of Social Research Methodology, 8*(1), 47-60.
- Butler, J. (2004). *Undoing Gender*. New York: Routledge.
- Butler, J. (1999). *Gender trouble: Feminism and the subversion of identity* (10<sup>th</sup> ed.). New York: Routledge.
- Butler, J. (1997). *Excitable speech: A politics of the performative*. London: Routledge.
- Campos, P. et al. (2006). The Epidemiology of Overweight and Obesity: Public Health Crisis or Moral Panic? *International Journal of Epidemiology 35*(1), 55-60.
- Chang, C., Chao, Y., & Kenney, N. J. (2006). I am a woman and I'm pregnant: Body image of women in Taiwan during the third trimester of pregnancy. *Birth, 33*(2), 147-153.
- Chapman, G. E. (1997). Making weight: Lightweight rowing, technologies of the power, and technologies of the self. *Sociology of Sport Journal, 14*, 205-223.
- Chase, L. F. (2006). (Un)disciplined bodies: A Foucauldian analysis of women's rugby. *Sociology of Sport Journal, 23*, 229-247.
- Chase, S. E. (2005). Narrative inquiry: Multiple lenses, approaches, voices. In N. K. Denzin & Y. Lincoln (Eds.), *The sage handbook of qualitative research* (3<sup>rd</sup> ed.) (pp. 651-680). Thousand Oaks, CA: Sage.
- Chavkin, W. (1992). Women and the fetus: The social construction of conflict. In C. Feinman (Ed.), *The criminalization of a woman's body* (pp. 193-202). New York: Harrington Park Press.

- Clarke, A. E., Mamo, L., Fishman, J. R., Shim, J. K., & Fosket, J. R. (2003).  
Biomedicalization: Technoscientific transformations of health, illness, and U.S.  
biomedicine. *American Sociological Review*, 68, 161-194.
- Cole, C. L. (1994). Resisting the canon: Feminist cultural studies, sport, and Technologies  
of the body. In S. Birrell & C. L. Cole (Eds.), *Women, sport, and Culture* (pp. 5-29).  
Champaign, IL: Human Kinetics.
- Cox, B. & Thompson, S. (2000). Multiple bodies: Sportswomen, soccer, and sexuality.  
*International Review for the Sociology of Sport*, 35(1), 5-20.
- Crandell, C. & Martinez, R. (1996). Culture, ideology, and antifat attitudes. *Personality &  
Social Psychology Bulletin*, 22, 1165-1176.
- Damm, P., Breitowicz, B., & Hegaard, H. (2007). Exercise, pregnancy, and insulin  
sensitivity - What is new? *Applied Physiology, Nutrition and Metabolism*, 32, 537-540.
- Darby, A., Hay, P., Mond, J., Rodgers, B., & Owen, C. (2007). Disordered eating behaviours  
and cognitions in young women with obesity: Relationship with psychological status.  
*International Journal of Obesity*, 31(8), 876-882.
- Davies, B. (1992). Women's subjectivity and feminist stories. In C. Ellis & M. G.  
Flaherty (Eds.), *Investigating subjectivity: Research on lived experience* (pp. 53-78).  
Newbury Park, CA: Sage.
- Davies, G., Wolfe, L., Mottola, M., & MacKinnon, C. (2003). Exercise in pregnancy and  
the postpartum period. Joint SOGC/CSEP Clinical Practice Guideline, no. 129, 1-7.
- Denzin, N. K. (2003). *Performance ethnography: Critical pedagogy and the politics of  
culture*. Thousand Oaks, CA: Sage.

- Deveaux, M. (1996). Feminism and empowerment: A critical reading of Foucault. In S. J. Hekman (Ed.), *Feminist interpretations of Michel Foucault* (pp. 137-156). University Park, PA: The Pennsylvania State University Press.
- Devine, C., Bove, C., & Olson, C. (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 & Medicine*, 50(4), 567-582.
- Duncan, M. C. (1994). The politics of women's body images and practices: Foucault, the panopticon, and Shape magazine. *Journal of Sport & Social Issues*, 18(1), 48-65.
- Dworkin, S. L. & Wachs, F. L. (2009). *Body panic: Gender, health, and the selling of fitness*. New York: New York University Press.
- Dworkin, S. L. & Wachs, F. L. (2004). "Getting your body back" Postindustrial fit motherhood in Shape Fit Pregnancy magazine. *Gender & Society*, 18(5), 610-624.
- Earle, S. (2003). 'Bumps and boobs': Fatness and women's experiences of pregnancy. *Women's Studies International Forum*, 26(3), 245-252.
- Ellis, C. & Bochner, A. P. (1992). Telling and performing personal stories: The constraints of choice in abortion. In C. Ellis & M. G. Flaherty (Eds.), *Investigating subjectivity: Research on lived experience* (pp. 79-101). Newbury Park, CA: Sage.
- Eskes, T. B., Duncan, M. C., & Miller, E. M. (1998). The discourse of empowerment: Foucault, Marcuse, and women's fitness texts. *Journal of Sport & Social Issues*, 22(3), 317-344.
- Evans, J., Rich, E., & Davies, B. (2004) The emperor's new clothes: Fat, thin and overweight. The social fabrication of risk and health. *Journal of Teaching Physical Education*, 23(4), 372-392.

- Featherstone, M. (1982). The body in consumer culture. *Theory, Culture & Society*, 1(2), 18-33.
- Ferraro, Z. & Adamo, K. B. (2008). Pediatric obesity: It's time for prevention before conception. Can maternal obesity program pediatric obesity? *Clinical Medicine: Pediatrics* 2, 37-46.
- Fortin, S., Cyr, C., & Tremblay, M. (2005). The act of listening to the art of giving voice: Creative alternative practices in writing about health in dance. *Dance Research Journal*, 37(2), 11-24.
- Foucault, M. (1972). *The archaeology of knowledge*. (Tavistock Publications Limited, Trans.) London, UK: Routledge (original work published 1969).
- Foucault, M. (1970). *The order of things: An archaeology of the human sciences*. (Unknown, Trans.) New York: Random House (original work published 1966).
- Foucault, M. (1977). *Discipline & punish: The birthplace of the prison*. (A. Sheridan, Trans.) New York: Vintage Books (original work published 1975).
- Foucault, M. (1978). *The history of sexuality: An introduction-vol. I*. (R. Hurley, Trans.) New York: Vintage Books (original work published 1976).
- Foucault, M. (2003). The birth of biopolitics. In P. Rabinow and N. Rose (Eds.), *The essential Foucault* (pp. 338-350). New York: The New Press.
- Fullager, S. (2003). Governing women's active leisure: The gendered effects of calculative rationalities within Australian health policy. *Critical Public Health*, 13(1), 47-60.
- Gaesser, G. A. (2003). Weight, weight loss, and health: A closer look at the evidence. *Healthy Weight Journal*, 17, 8-11.
- Gard, M. & Wright, J. (2005). *The obesity epidemic: Science, morality, and ideology*. London: Routledge.

- Greer, G. (1984). *Sex and destiny: The politics of human fertility*. London: Secker and Warburg.
- Gorelick, S. (1991). Contradictions of feminist methodology. *Gender and Society*, 5(4), 459-477.
- Haber, H. F. (1996). Foucault pumped: Body politics and the muscled woman. In S. J. Hekman (Ed.), *Feminist interpretations of Michel Foucault* (pp. 137-156). University Park, PA: The Pennsylvania State University Press.
- Harding, S. (1987). Introduction: Is there a feminist method? In S. Harding (Ed.), *Feminism and methodology: Social science issues*, (pp. 1-14). Bloomington, IN: Indiana University Press.
- Hartly, C. (2001). Letting ourselves go. In K. LeBesco & K. E. Brazier (Eds.), *Bodies out of bounds: Fatness and transgression* (pp. 60-73). California: University of California Press
- Hartsock, N. (1996). Postmodernism and political change: Issues for feminist theory. In S. J. Hekman (Ed.), *Feminist interpretations of Michel Foucault* (pp. 137-156). University Park, PA: The Pennsylvania State University Press.
- Health Canada. (December, 2006). Obesity: It's your health. *Healthy living*. Retrieved from <http://www.hc-sc.gc.ca/hl-vs/iyh-vsv/life-vie/obes-eng.php>
- Hekman, S. J. (1990). *Gender and knowledge: Elements of a postmodern feminism*. Boston: Northeastern University Press.
- Helstein, M. T. (2007). Seeing your sporting body: Identity, subjectivity, and misrecognition. *Sociology of Sport Journal*, 24, 78-103.
- Herrick, C. (2007). Risky bodies: Public health, social marketing and the governance of obesity. *Geoforum*, 38(1), 90-102.
- Holm, S. (2007). Obesity interventions and ethics. *Obesity Reviews*, 8(S1), 207-210.

- Holstein, J. A. & Gubrium, J. F. (2005). Interpretive practice & social action. In N. K. Denzin & Y. Lincoln (Eds.), *The sage handbook of qualitative research* (3<sup>rd</sup> ed.) (pp. 483-506). Thousand Oaks, CA: Sage Publications, Inc.
- Jansen, G. & Davis, D. (1998). Honouring voice and visibility: Sensitive-topic research and feminist interpretive inquiry. *Affilia Journal of Women and Social Work*, 13(3), 289-312.
- Jette, S. (2006). Fit for two? A critical discourse analysis of Oxygen fitness magazine. *Sociology of Sport Journal*, 23, 331-351.
- Johnson, S., Burrows, A., & Williamson, I. (2004). 'Does my bump look big in this?' the meaning of bodily change for first-time mothers-to-be. *Journal of Health Psychology*, 9, 361-374.
- Jovanovic, L. (2001). What is so bad about a big baby? *Diabetes Care*, 24(8), 1317-1318.
- Jutel, A. M. (2001). Does size really matter? Weight and values in public health. *Perspective in Biology and Medicine* 44(2), 283-289.
- Kent, L. (2001). Fighting abjection: Representing for women. In K. LeBesco & J. E. Braziel (Eds.), *Bodies out of bounds: Fatness and transgression* (pp. 130-152). California: University of California Press.
- Kidd, J. & Finlayson, M. (2009). When needs must: Interpreting autoethnographical stories. *Qualitative Inquiry*, 15(6), 980-995.
- Klein, M. (1988). Women in the discourse of sport reports. *International Review for Sociology of Sport*, 23(2), 139-152.
- Kvale, S. (1996). *InterViews: An introduction to qualitative research interviewing*. Thousand Oaks, CA: Sage Publications.
- Kvale, S. & Brinkmann, S. (2009). *InterViews: Learning the craft of qualitative research interviewing* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage Publications.

- Kuhlmann, A. K., Dietz, P. M., Galavotti, C., & England, L. J. (2008). Weight management interventions for pregnant or postpartum women. *American Journal of Preventative Medicine*, 34(6), 523-527.
- Lane, K. (2008). The medical model of the body as a site of risk: A case study of childbirth. In C. Malacrida & J. Low (Eds.), *Sociology of the body: A reader* (pp.157-164). London: Oxford University Press.
- Lang, T. & Rayner, G. (2007). Overcoming policy cacophony on obesity: An ecological public health framework for policymakers. *Obesity Reviews*, 8(S1), 165-181.
- Lazarus, E. S. (1994). What do women want?: Issues of choice, control, and class in pregnancy and childbirth. *Medical Anthropology Quarterly*, 8(1), 25-46.
- LeBesco, K. (2001). Queering fat bodies/politics. In K. LeBesco & J. E. Braziel (Eds.), *Bodies out of bounds: Fatness and transgression* (pp. 74-90). California: University of California Press.
- Lloyd, M. (1996). Feminism, aerobics and the politics of the body. *Body Society*, 2(2), 79-98.
- Lock, M. (1998). Situating women in the politics of health. In S. Sherwin (Ed.), *The politics of women's health: Exploring agency and autonomy* (pp. 48-63). Philadelphia: Temple University Press.
- Longhurst, R. (2005). Fat bodies: Developing geographical research agendas. *Progress in Human Geography*, 29(3), 247-259.
- Longhurst, R. (2001). *Bodies: Exploring Fluid Boundaries*. London: Routledge.
- Lupton, D. (1999). Risk and the ontology of pregnant embodiment, In Lupton, D. (Ed.), *Risk and sociocultural theory: New directions and perspectives* (pp. 59-85). Cambridge: Cambridge University Press.

- MacNeill, M., & Rail, G. (2010). The visions, voices and moves of young “Canadians”:  
Exploring diversity, subjectivity and cultural constructions of fitness and health. In J.  
Wright & D. Macdonald (Eds.), *Young people, physical activity and the everyday* (pp.  
175-193). London and New York: Routledge.
- Maguire, J. S. (2002). Michel Foucault: Sport, power, technologies and governmentality. In J.  
Maguire & K. Young (Eds.), *Theory, sport & society* (pp. 293-314). Boston: JAI.
- Markens, S., & Browner, C. H. (1997). Feeding the fetus: On interrogating the notion  
maternal-fetal conflict. *Feminist Studies*, 23(2), 351-372.
- Markula, P. (2004). “Tuning into one’s self:” Foucault’s technologies of the self and  
Mindful fitness. *Sociology of Sport Journal*, 21, 302-321.
- Markula, P. (2003). The technologies of the self: Sport, feminism, and Foucault. *Sociology of  
Sport Journal*, 20, 87-107.
- Markula, P. (2001). Beyond the perfect body: Women’s body image distortion in fitness  
Magazine discourse. *Journal of Sport & Social Issues*, 25(2), 158-179.
- Markula, P. (1995). Firm but shapely, fit but sexy, strong but thin: The post-modern  
aerobicizing female bodies. *Sociology of Sport Journal*, 12, 424-453.
- Martin, E. (1987). *The woman in the body: A cultural analysis of reproduction*. Boston: Beacon  
Press.
- McKinley, N. M. (2004). Resisting body dissatisfaction: Fat women who endorse fat  
acceptance. *Body Image*, 1, 213-219.
- McNay, L. (1991). The Foucauldian body and the exclusion of experience. *Hypatia*, 6(3), 125-  
140.
- Mills, S. (1997). *The new critical idiom*. London: Routledge.

- Mitchinson, W. (2002). *Giving birth in Canada: 1900-1950*. Toronto: University of Toronto Press.
- Monaghan, L. F. (2005). Discussion piece: A critical take on the obesity debate. *Social Theory & Health*, 3, 302-314.
- Morgan, K. P. (1991). Women and the knife: Cosmetic surgery and the colonization of Women's bodies. *Hypatia*, 6(3), 25-53.
- Morgan, K. (1998). Contested bodies, contested knowledges: Women, health, and the politics of medicalization. In S. Sherwin (Ed.), *The politics of women's health: Exploring agency and autonomy*, (pp. 48-63). Philadelphia: Temple University Press.
- Murray, S. (2007). Corporeal knowledges and deviant bodies: Perceiving the fat body. *Social Semiotics*, 17(3), 361-373.
- National Institutes of Health. (November, 2008). Understanding adult obesity. *Weight control information network: An information service of the national institute of diabetes and digestive and kidney diseases*. Retrieved from <http://win.niddk.nih.gov/publications/understanding.htm>
- Oakely, A. (1990). Who's Afraid of the Randomized Controlled Trial? Some Dilemmas of the Scientific Method and 'Good' Research Practice. In H. Roberts (Ed.), *Women's Health Counts*, (pp. 167-194). London: Routledge.
- Oakely, A. (1980). *Women confined: Towards a sociology of childbirth*. New York: Schocken Books.
- Oliver, E. (2005). *Fat politics: The real story behind America's obesity epidemic*. New York: Oxford University Press.
- Olson, C. L., Schumaker, H. D., & Yawns, B. P. (1994). Overweight women delay medical care. *Archives of Family Medicine* 3, 888-892.

- Orbach, S. (2006). Commentary: There is a public health crisis-it's not fat on the body but fat in the mind and the fat of profits. *International Journal of Epidemiology* 35, 67-69.
- Parry, D. C. (2006). Women's lived experiences with pregnancy and midwifery in medicalized and fetocentric context: Six short stories. *Qualitative Inquiry*, 12(3), 459-471.
- Polley, B., Wing, R., & Sims, C. (2002). Randomized controlled trial to prevent excessive weight gain in pregnant women. *International Journal of Obesity*, 26, 1494-1502.
- Pollit, K. (2008). 'Fetal rights': A new assault on feminism. In C. Malacrida & J. Low (Eds.), *Sociology of the body: A reader* (pp. 183-188). London: Oxford University Press.
- Probyn, E. (2008). IV. Silences behind the mantra: critiquing feminist fat. *Feminism & Psychology* 18(3), 401-404.
- Rail, G., Holmes, D., & Murray, S.J. (2010). The politics of evidence on "domestic terrorists": Obesity discourses and their effects. *Social Theory and Health*, 8(3), 259-279.
- Rail, G., & Lafrance, M. (2009). Confessions of the flesh and biopedagogies: Discursive constructions of obesity on Nip/Tuck. *Medical Humanities*, 35, 76-79.
- Rail, G. (2009). Canadian youth's discursive construction of health in the context of obesity discourse. In J. Wright & V. Harwood (Eds.), *Biopolitics and the 'obesity epidemic': Governing bodies* (pp. 141-156). New York, NY: Routledge.
- Rail, G. (2002). Postmodernism and sport studies. In J. Maguire & K. Young (Eds.), *Theory, sport & society* (pp. 293-314). Boston: JAI.
- Rail, G. & Harvey, J. (1995). Body at work: Michel Foucault and the sociology of sport. *Sociology of Sport Journal*, 12, 164-179.
- Raphael, D. (2003). Addressing the social determinants of health in Canada: Bridging the gap between research findings and public policy. *Policy Options, March*, 35- 44.

- Rice, C. (1995). *Promoting Healthy Body Image: A guide for program planners*. Toronto, ON, Canada: Ontario Ministry of Health, Best Start Community Action for Healthy Babies.
- Riemann, M. K. & Hansen, K. (2000). Effects on the foetus of exercise in pregnancy. *Scandinavian Journal of Medical Science and Sports* 10, 12-19.
- Richardson, L. (1992). The consequences of poetic representation: Writing the other, rewriting the self. In C. Ellis & M. G. Flaherty (Eds.), *Investigating subjectivity: Research on lived experience* (pp. 125-140). Newbury Park, CA: Sage Publications.
- Rothblum, E. (1990). Women and weight: Fad and fiction. *Journal of Psychology*, 124, 5-24.
- Root, R. & Browner, C. (2001). Practices of the pregnant self: Compliance with and resistance to prenatal norms. *Culture, Medicine and Psychiatry*, 25(2), 195-223.
- Ross, B. (2005). Fat or fiction: Weighing the obesity epidemic. In M. Gard & J. Wright (Eds.), *The obesity epidemic: Science, morality, and ideology* (pp. 86-106). London: Routledge.
- Rudolfsdottir, A. G. (2000). 'I am not a patient, and I am not a child': The institutionalization and experience of pregnancy. *Feminism Psychology*, 10, 337-350.
- Ruhl, L. (1999). Liberal governance and prenatal care: Risk and regulation in pregnancy. *Economy and Society*, 28(1), 95-117.
- Saguy, A. C. & Almeling, R. (2008). Fat in the fire? Science, the news media, and the "obesity epidemic". *Sociological Forum*, 23(1), 56-83.
- Scott-Dixon, K. (2008). Big girls don't cry: Fitness, fatness, and the production of feminist knowledge. *Sociology of Sport Journal* 25, 22-47.
- Seibold, C. (2003). Young single women's experiences of pregnancy, adjustment, decision-making and ongoing identity construction. *Midwifery*, 20, 171-180.
- Seiga-Riz, A. M., Evenson, K. R., & Dole, N. (2004). Pregnancy-related weight gain-A link to obesity? *Nutrition Reviews*, 62(7), S105-S111.

- Shilling, C. (1993). *The body and social theory*. London, UK: Sage.
- Smith, S. A., Hulsey, T. & Goodnight, W. (2008). Effects of obesity on pregnancy. *JOGNN*, 37, 176-184.
- Society of Obstetricians and Gynecologists of Canada. (February 2010). *SOGC clinical practice guideline: Obesity in pregnancy* (no. 239). Davies, G., Maxwell, C. & McLeod, L.
- Sprague, J. (2005). *Feminist methodologies for critical researchers: Bridging differences*. Walnut Creek, CA : Lanham.
- Treichler, P. A. (1990). Feminism, medicine, and the meaning of childbirth. In M. Jacobus, E. F. Keller, & S. Shuttleworth (Eds.), *Body/politics: Women and the discourses of science* (pp.113-138). New York: Routledge.
- Twigg, J. (2006). *The body in health and social care*. New York: Palgrave Macmillan.
- Warren, S. & Brewis, J. (2004). Matter over mind? Examining the experience of pregnancy. *Sociology*, 38(2), 219-236.
- Weedon, C. (1997). *Feminist practice and poststructuralist theory* (2<sup>nd</sup> ed.). United Kingdom: Blackwell Publishing.
- Weedon, C. (1991). Post-structuralist feminist practice. In D. Morton & M. Zavarzadeh (Eds.), *Texts for change: Theory/pedagogy/politics* (pp. 47-63). Illinois: University of Illinois Press.
- Weir, L. (2006). *Pregnancy, risk and biopolitics: On the threshold of the living subject*. Oxon, UK: Routledge.
- Weissgerber, T., Wolfe, L., Davies, G., & Mottola, M. (2006). Exercise in the prevention and treatment of maternal-fetal disease: A review of the literature. *Applied Physiology, Nutrition, and Metabolism*, 31, 661-674.

- Wiles, R. (1994). 'I'm not fat, I'm pregnant': The impact of pregnancy on fat women's body image. In Sue Wilkinson, & Celia Kitzinger (Eds.), *Women and health: Feminist perspectives* (pp. 33–48). London: Taylor and Francis.
- Wilson, N. (2005). Vilifying former fatties: Media representations of weight loss surgery. *Feminist Media Studies*, 5(2), 252-255.
- Wolf, N. (1990). *The beauty myth*. Toronto: Random House.
- World Health Organization. (2010). Obesity and overweight. *World Health Organization media centre*. Retrieved from <http://www.who.int/mediacentre/factsheets/fs311/en/index.html>
- Wright, J. (1995). A feminist poststructuralist methodology for the study of gender construction in physical education: Description of a study. *Journal of Teaching in Physical Education*, 15, 1-24.
- Young, M. (2005). One size fits all: Disrupting the consumerized, pathologized, fat female form. *Feminist Media Studies*, 5(2), 249-252.
- Young, I. M. (1990). *On female body experience: "Throwing like a girl" and other essays*. London: Oxford University Press.
- Young, I. M. (1984). Pregnant embodiment: Subjectivity and alienation. *The Journal of Medicine and Philosophy*, 9, 45-62.

## APPENDIX A

### CONVERSATION GUIDE

#### Discursive constructions of health and obesity among pregnant women

Below are examples of questions that may be asked. Because the method calls for a conversation and because conversations usually take the direction the participants want to, not all questions will be asked and the order of the questions will vary from one participant to the other.

#### PART I – PREGNANCY

- a) How would you explain/describe your situation, the "culture" surrounding pregnancy?
- b) What do you take from it?
- c) How is the culture of pregnancy different from the mainstream culture or the culture of women who are NOT pregnant?
- d) What do you take from mainstream culture?
- e) Do you consider yourself more as part of mainstream culture or as part of the culture of pregnant women (how different do you feel from other women)? How? Why?
- f) How do you define your own identity (who you are)? Are you closer to ordinary women or to women who are pregnant?

#### PART II – HEALTH

1. Constructions of health
  - a) What does health mean to you?
  - b) What are the key words that define health?
  - c) Can you describe a person who is in good health?
  - d) What qualities does she have?
  - e) Is being healthy different or similar for men and women? How?
2. Sources of the constructions of health
  - a) Where do your ideas about health come from?
  - b) Where do you search for information?
  - c) Is there a lot of information available in society? Are you interested in this information? Why/Why not?
  - d) Do you trust health information? What sources do you (most/least trust)?
3. Integration of health practices in everyday life
  - a) Is your health a priority in your life? Why/Why not?
  - b) Do you take care of your health? How?
  - c) Do you think that you are in good health? What makes you say that?

- d) Why do you think you are healthy/unhealthy?
- e) Are you worried about your health? Why?
- f) What do you do to be or stay healthy?
- g) What do you think you could do to improve your health?
- h) What are the things that prevent you from taking care of your health?

4. “Culture” of pregnancy and constructions of health

- a) How does being pregnant affect your health practices?
- b) Has your perception of health practices changed now that you are pregnant? Why?
- c) Do you feel more pressure to be healthy now that you’re pregnant?
- d) Do you feel that your health practices will affect the health of your baby? Why or why not?
- e) Do you know other pregnant women? Do you see them from time to time?
- f) When you discuss pregnancy, do you talk about health practices?
- g) Do you think that pregnant women think about health the same way as women who are not pregnant? How is that so?
- h) Do you believe that your pregnancy is an obstacle or a helping factor to achieve health? Why?

### PART III – OBESITY

5. Constructions of obesity

- a) What is obesity for you?
- b) What are the key words that define obesity?
- c) Is obesity different or similar for men and women? How? Why?
- d) How do you feel about obesity? About an overweight person?
- e) Does overweight or obesity worry you? Why? Why not?

6. Sources of constructions of obesity

- a) Where do your ideas about obesity come from?
- b) Is there a lot of information on obesity?
- c) Are you interested in this information? Why/Why not?
- d) How do you feel about the information you get on obesity?
- e) Do you trust this information? What sources do you most/least trust?
- f) There is media attention on obesity. How do you feel about that?

7. “Culture” of pregnancy and constructions of obesity

- a) Has your perception of obesity changed now that you are pregnant? Why?
- b) Has your changing body shape affected your perception of obesity?
- c) When you discuss pregnancy with other pregnant women, do you talk about weight/obesity?
- d) Do you think that pregnant women think about obesity the same way as women who are not pregnant? How is that so?

8. Body, obesity, and disciplining practices

- a) Do you grant much importance to your body? Why? What is important for you?
- b) Do you care about your weight? Why? What do you do to maintain/lower/increase your weight? Why do you think you have to do this?
- c) What is, according to you, the ideal weight of a woman of your age?
- d) In this moment, in a general way, are you satisfied with your appearance?
- e) Who or what do you think has the biggest influence on your body? Why?
- f) Have you ever followed a diet (which methods were used)? Why? (Probe here to get info on the desired outcomes internal to the body (health, performance, self-confidence, etc.) or external to the body (aesthetic, appreciation of others, friendship, social acceptance, etc.)
  
- g) Are there any aspects which disturb you when you hear the description of certain women? Certain pregnant women?
- h) Are there any aspects which disturb you in the way in which women discuss their weight?
- i) Is there anyone who has made you feel like you were not the right weight? Can you speak to me about that (feelings and actions undertaken, etc.)?

**APPENDIX B****INFORMAL PRESENTATION TEXT****Discursive constructions of health and obesity  
among young pregnant women**

Hello,

My name is Emma Harper and I am a Master's student at the University of Ottawa. I am writing to you today because I am involved in a research study conducted by Dr. Geneviève Rail, a University of Ottawa professor in the Faculty of Health Sciences. The project involves exploring the perceptions of health and the body among young pregnant women.

I am specifically looking for pregnant women who are between 18 and 28 years of age to take part in a one-on-one interview that would take about 1 to 2 hours. The interview would be in English and in the form of an informal conversation with me and would be on health and the body, what it means to you, where you get your ideas about these issues and would consist of these types of questions. I am looking for volunteers who would be interested in answering these questions. The interview would be confidential and I would use a fake name when I transcribe the interview. I would make sure that any element that could identify you would be deleted from the transcript. The interview transcript would be for research purposes only and would remain confidential.

If you are interested in participating in this interview, please contact me via email and I will contact you as soon as possible to discuss the study in further detail and to see whether you would still volunteer to participate. If that is the case, then you will be able to select a place where you would want the conversation to take place as well as a time that is convenient to you.

Participation in this study is voluntary. If you choose to participate, you are free to withdraw at any point in time and for any reason.

Please feel free to ask me any questions you may have regarding this study.

Thank you for your time and consideration.

Emma Harper  
Master's Student  
Faculty of Health Sciences  
University of Ottawa

## APPENDIX C

**INTERVIEW CONSENT FORM****Discursive constructions of health and obesity  
among young pregnant women****Principal Researcher:**

Geneviève Rail, Ph.D.  
Faculty of Health Sciences  
University of Ottawa  
Ottawa, Ontario, K1N 6N5

**Graduate Assistant:**

Emma Harper, B.Sc  
Faculty of Health Sciences  
University of Ottawa  
Ottawa, Ontario, K1N 6N5

***Note:***

Whenever a research project involves humans, the written consent of the research participants must be obtained. This does not imply that the project involves a risk. In view of the respect owed to the research participants, the University of Ottawa and the research funding agencies have made this type of agreement mandatory.

\*\*\*\*\*

I, \_\_\_\_\_, am invited to collaborate voluntarily and freely in the research supervised by Dr. Geneviève Rail and conducted with the assistance of Emma Harper of the Faculty of Health Sciences at the University of Ottawa.

I understand that the general goal of this study is to examine pregnant women's ideas about health and the body. The specific objectives of this study are to explore these women's: (a) views of health, the body and obesity; (b) relationships between their views and the views present in the media and society in general; (c) experiences of health and the body in their everyday lives (e.g., how they make decisions about their health practices).

My participation will consist of (1) taking part in a one-on-one interview session to discuss ideas of health, the body and obesity. That interview will be in English and will last between 1 to 2 hours and will take place at a time and place of my choosing. (2) If need be, my participation will also consist of taking part in a follow-up session. That session would take place if additional information and/or clarification are necessary. The follow-up session would be done over the telephone and would last 30 minutes at the most. (3) I understand that I will be sent via mail the written transcription of my interview. I will be offered the opportunity to read that transcription and to provide corrections/deletions/additions to it via mail. (4) Finally, toward the end of the study, I will be provided with an electronic version of a 2-page story summarizing the results of the study and I will be offered the opportunity to send, via email, feedback on this story, for instance, to comment on whether the story is realistic and corresponds to my situation or that of other young pregnant women I know.

I grant permission for the digital recording of my interview(s) for the purposes of this study. I understand that my interview(s) will be transcribed and that I will have the opportunity to re-read and change, remove or correct any passages of the transcript that I feel may not be appropriate.

I accept that all materials (interview transcripts, feedback sent through email) collected as a result of my participation in the study will be used strictly for research purposes, that they will be available only to Dr. Rail and graduate student Emma Harper and that my anonymity and confidentiality will be protected at all times. I am assured that the digital tape and the transcript of the interview(s) will be kept in a locked filing cabinet in the office of Dr. Rail at the University of Ottawa during the time of the study. The digital tape will be destroyed at the end of the study. Other papers or electronic files (i.e., emails, electronic copies of my interviews transcription, etc.) will be kept for 5 years, after which time they will be shredded or erased. I understand that I may withdraw this permission at any time and that any recordings of my participation will be erased at once upon my request without fear of negative consequences.

I have also been assured by the researcher that any information that I have shared will remain strictly confidential. My anonymity is also guaranteed. I will be assigned a fake name and this fake name will be used in the interview transcription. Should the researchers cite a portion of my interview in their study, my fake name will be used and all information that may reveal my identity will be deleted.

I acknowledge that given the nature of this research, I will be required to express or share personal information and, as a result, there may be a minimal level of emotional discomfort at certain moments. I have received assurance that the interviewer will do everything she can to minimize the risk of discomfort. Moreover, I will not be required to respond to any question that may bring discomfort, and should I choose not to answer a question, there will be no negative consequences for me. The interview will be conducted in a very informal manner where the questions will be posed in simple language. In the event that I do not understand a question being posed, it will be rephrased in such a manner that it can be more easily understood. Finally, I am free to withdraw from the study at any time before or during the interview, without prejudice.

I understand that I will be asked to sign both copies of the consent form, and that one of the copies will be for me (the other will be kept in a locked filing cabinet by Dr. Rail).

For any additional information, I have been informed that I can contact Emma Harper or Dr. Rail at any time. For all other complaints concerning ethical conduct in this study, I have been informed that I can address myself to the Protocol Officer for Ethics in Research, Office of Vice-Rector Research, University of Ottawa, at (613) 562-5841, by email at [ethics@uottawa.ca](mailto:ethics@uottawa.ca) or by mail at Tabaret Hall (159), 550 Cumberland Street, Ottawa, Ontario, K1N 6N5.

I, \_\_\_\_\_, freely and voluntarily consent to take part in this study.

**Participant :** \_\_\_\_\_  
**Signature** **Date**

I, \_\_\_\_\_, declare having explained the objectives, the nature and any inconvenience of the study to the participant mentioned above. I commit myself to the strictest confidentiality with respect to the information received in this study.

**Interviewer :** \_\_\_\_\_  
**Signature** **Date**

## APPENDIX D

### Karen's Story

The alarm at the head of Karen's bed sounds. Ugh, at eight months pregnant, she feels like a beached whale. She slowly slides herself to the side of the bed, and heaves her body to a standing position. This heaviness, the swelling, the aching, the discomfort... Ha! She laughs, at least she's not nauseous anymore and barely able to eat like in her first trimester.

She pauses to admire her pregnant belly in the mirror, in complete awe of what women are capable of, that there is actually another being growing inside of her. It really was a beautiful thing. How bittersweet the whole ordeal has been, her body being all out of whack, permanent stretch marks, clothes that don't fit. She figures, who wouldn't feel frustrated sometimes at losing their body...

Think of the baby! It's all for the baby. And, it's normal, this is normal, as she stares at herself more intently in the mirror. If she wasn't pregnant it would be different, weight gain is not something she would normally be okay with. But, weight gain is normal during pregnancy, you're supposed to, for the baby. Who cares, right? And, well her mom said she gained 60 lbs. So every woman's body is different. She'll worry about it afterwards.

Although, she can't help giving a small sigh of relief. At least she gained what all the books and doctors recommend, that is one less thing to be anxious about. And, well she's been eating well and walking for exercise, so why wouldn't she gain the right amount.

She pauses to think about her health. She's doing everything she can. She's read all the books, subscribes to the Baby Centre E-letter, stays in regular contact with her health care practitioner. Being healthy requires work and self-control, especially while you're pregnant. Making sure you eat the right foods, getting the proper amount of calories, staying active (but not overdoing it), all this could have very real effects on her baby. It was her responsibility to take care. She

rephrases, it was every pregnant woman's responsibility to take care of their health for their unborn baby.

Still... sometimes it's hard, and listening to her body was an important part of health too. Occasionally, that even meant giving into cravings or skipping that exercise because she just felt too sore. Not to mention having the time. Oh, the time! She had better get a move on. She was moving in a couple weeks and needed to pack more boxes, not to mention cleaning up the house and getting dinner ready for later on. Sometimes, by the end of the day, she thinks to herself, she just deserves that chocolate bar.

Questions:

- 1) Does Karen reflect your experiences while pregnant? Why or why not.
- 2) Is there anything in Karen's story that you don't agree with? Can you explain?
- 3) Is there anything about your own or someone else's experience that you feel is important to add to this story?

**APPENDIX E****DIARY: Body Stories**

June 23, 2009 (14 wks pregnant)

I still can't believe I'm pregnant! But when will I start to look pregnant? I mean maybe my clothes are getting tighter because I'm eating too much. I need to watch what I eat... I've seen other women who ate a lot during their pregnancy, and even afterwards they're still huge. But, it is normal to gain weight during pregnancy, and each woman is different. Your body knows what it's doing, you need to listen to it. I mean there's only so much I can control anyway. Regardless my body is going to do what it wants. It's hard though, and I've heard it just gets harder as your body is changing and stretching, and your clothes aren't fitting. I just want some feeling of normalcy throughout. I don't want to lose the body I feel comfortable with.

Aug. 19, 2009 (22 wks pregnant)

I've decided I dress for comfort now. Who cares how I look? I'm not trying to impress anyone. I'm pregnant! But sometimes it's hard. Yesterday we got pictures back from the California trip. I want to be comfortable, but I looked like a COW in my dress compared to everyone else! But I can't stress about my body during pregnancy. I mean, usually pregnancy feels like a nice vacation from having to worry about that little beer gut that normally bothers me so much. I just don't want to gain too much weight! It's already hard to look down at that scale and see the numbers I'm seeing now. I've never been this big before. I'll be pushing 170, and in my head, the way I've been conditioned it's scary! But, pregnancy means weight gain, I shouldn't care about looking fat right now, I should enjoy the big belly. I mean at least I haven't gained a bunch in my face and arms. Why are we so hard on ourselves?

Sept. 25, 2009 (27 wks pregnant)

I AM SO ANGRY! I couldn't believe what my boss said to me today. Kelly, one of my other coworkers gained a lot of weight all over when she was pregnant, and he said he hopes I don't turn out like her. Who does he think he is? Pregnant women are gaining for a reason! We're not fat! There's a living growing being inside, pushing out our bellies, affecting our entire body. How are we supposed to feel? I'm doing the best I can. I'm eating properly and exercising. People expect us to be these silhouettes of pregnant women, just a belly. It makes me so mad!

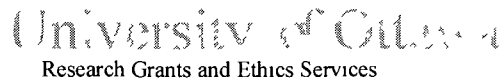
Oct. 15, 2009 (31 wks pregnant)

I've been really admiring the shape that my pregnant body is taking. What an amazing and beautiful thing. Now it's just afterwards, that gets to me sometimes. I promised myself that once this baby is out I'm going to be in a bikini by the summer. It's just hard knowing money and time are going to be tight afterwards. It will be hard to cook healthy meals and go to the gym. I'm worried about my stretch marks too. I mean how can you look sexy with stretch marks all over your stomach? Hopefully the creams I've been using do something. Although, I keep telling myself it will be worth it in the end. Going through this incredible ordeal there are bound to be battle scars.

QUESTIONS:

- 1) Do these diary entries reflect yours or someone you know beliefs about their body during pregnancy? How so?
- 2) Is there anything that stands out to you that you really agree with or don't agree with? Can you explain?
- 3) Is there anything else you would add to these diary entries?

**APPENDIX F**



## Ethics Approval Notice

### Health Sciences and Science REB

**Principal Investigator / Supervisor / Co-investigator(s) / Student(s)**

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Geneviève	Rail	Health Sciences / Human Kinetics	Principal Investigator
Emma	Harper	Health Sciences / Human Kinetics	Student Researcher

**File Number:** H02-09-16

**Type of Project:** Professor

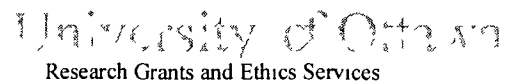
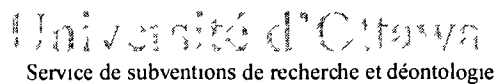
**Title:** Discursive Constructions of Health and Obesity Among Young Pregnant Women

<b>Renewal Date (mm/dd/yyyy)</b>	<b>Expiry Date (mm/dd/yyyy)</b>	<b>Approval Type</b>
05/29/2010	05/28/2011	Ia

**(Ia: Approval, Ib: Approval for initial stage only)**

**Special Conditions / Comments:**

N/A



This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled “Special Conditions / Comments”.

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the “Modification to research project” form available at:  
[http://www.rges.uottawa.ca/ethics/application\\_dwn.asp](http://www.rges.uottawa.ca/ethics/application_dwn.asp)

Please submit an annual status report to the Protocol Officer 4 weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at:  
[http://www.rges.uottawa.ca/ethics/application\\_dwn.asp](http://www.rges.uottawa.ca/ethics/application_dwn.asp)

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5841 or by e-mail at: [ethics@uOttawa.ca](mailto:ethics@uOttawa.ca).

**Signature:**

Germain Zongo  
Protocol Officer for Ethics in Research  
For Daniel Lagarec, Chair of the Sciences and Health Sciences REB