UNIVERSITY OF SOUTHAMPTON

# THE IMPACT OF PREGNANCY ON FAT WOMEN'S BODY IMAGE AND EATING PRACTICES

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UNIVERSITY OF SOUTHAMPTON

ABSTRACT

FACULTY OF SOCIAL SCIENCE

SOCIOLOGY AND SOCIAL POLICY

Doctor of Philosophy

# THE IMPACT OF PREGNANCY ON FAT WOMEN'S BODY IMAGE AND EATING PRACTICES

by Rosemary Angela Wiles

Fatness is a state that is viewed as undesirable from both a health and aesthetic viewpoint. Fat people are often viewed and treated in negative ways and there is great social pressure for them to become slim. Fat women are more likely than fat men to experience their fatness negatively and to experience discrimination as a result of their size. This difference occurs as a result of the emphasis that is placed on women's physical appearance in patriarchal society.

The only way that fat people can become slimmer is to alter their diet in some way. For women this is often very difficult because of the conventions surrounding family mealtimes and the close contact they have with food as a result of their social roles.

This study examines the impact of pregnancy on fat women's feelings about their weight and their eating practices. A total of 37 women were interviewed both before and after pregnancy using qualitative research methods.

Pregnancy had an impact on many of the women's feelings about their weight and/or their eating practices and some of these changes survived into the post-pregnancy period. In the post-pregnancy period, a link was found between women's feelings about their weight and their eating practices and the factors that contributed to these particular attitudes are identified. The implications for medical professionals of these findings are discussed. An analysis of why fat women feel so negatively about their size and strategies for changing the emphasis on women's physical appearance are examined.

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# CHAPTER ONE: A REVIEW OF THE LITERATURE ON FAT WOMEN AND PREGNANCY

## 1.1 INTRODUCTION

This thesis is concerned with the impact of pregnancy on fat women's feelings and experiences of their weight and on their eating behaviour. These two issues of body image and eating behaviour form the basis of this thesis and they are closely related topics. In a study focussing on the experience of fatness it is not possible to ignore the impact of eating, given that diet is seen popularly and medically as both a major cause of and a cure for fatness. The first part of this chapter will focus on the first of these issues, the experience of fatness, and the second part will focus on eating behaviour. In discussing these two topics I will review relevant literature from feminism, sociology, psychology, social-psychology and medicine.

Before moving on to this there are two preliminary points that need to be made. The first relates to my intention to review literature from a wide range of disciplines. Sociology as a discipline has paid scant attention to topics relating specifically to people's physical attributes or functioning, such as weight and eating. There is some sociological literature that focusses on issues relating to this topic but sociological literature which focusses on weight and eating specifically is sparse, although there is evidence that this is changing (Turner, 1984; Charles and Kerr, 1988; Shilling, forthcoming). Traditionally these topics have been seen as the domain of the biological sciences and there is an extensive literature from these disciplines that has focussed on the extent, causes and consequences of fatness and has put forward possible solutions or cures for it. The experience of fatness has not been analysed in any depth in this

literature but it has been examined in a steady stream of feminist literature. A discussion of the literature from these fields, then, is necessary because it constitutes the dominant view that exists on the topic. Furthermore, an examination of this is desirable because this perspective has an impact on experience. The knowledge that exists in society about fatness and its relationship to diet is dominated by a medical model and this inevitably has an impact on the ways that people experience fatness. Indeed, much of the feminist literature highlights the impact that this medical model has.

The second preliminary point relates to the use of different terms employed in the literature to describe fatness. I intend to use the word 'fat' throughout this thesis rather than the words 'obese', 'overweight' or 'large' that are preferred in much of the literature. I have chosen to use this word for several reasons. First, 'fat' is a fairly clear, descriptive word that conjures up a commonsense image of the condition that is being focussed on here, unlike words such as 'large' which are rather more ambiguous. Secondly, unlike 'obese', it is a lay rather than a medical term and this is important given that this study focusses on women's perceptions of their weight and size. Thirdly, while the word 'fat' traditionally has negative connotations, it is used in the fat liberationist literature as a positive word (Schoenfielder and Wieser, 1983). This literature seeks to transform the word 'fat' into a positive adjective for fat people just as the black liberation movement attempted to do with the word 'black'. I want to use the word 'fat' here not especially in a positive way, as the fat liberationists have, but rather in a way that does not carry a value judgement that fat is wrong, as the word 'overweight' would imply. I

use it simply as an adjective to describe a particular kind of bodyshape.

## 1.2 THE EXPERIENCE OF FATNESS FOR WOMEN

The experience of fatness for women is not something that exists in a vacuum. It is shaped by the the meanings given to fatness and to womanhood in our society. In examining the experience of fatness for women, two issues need to be focussed on: first, societal attitudes towards fatness and what the experience of fatness in general is like and, secondly, in what ways women's experience of fatness may be different to men's.

### 1.2(i) Societal Attitudes Towards Fatness

Attitudes towards fat people in society are undoubtedly influenced by many factors. First, the attitudes displayed and mediated by the medical profession are likely to be important. As a result of increasing medicalisation, the medical profession has the power to set standards of 'normality' in many areas of life, one of which is bodyweight. Given the high level of status afforded to the medical profession, the attitudes and advice given by its members in relation to weight is likely to be a strong influence on people's views about, and attitudes towards, fat people. Secondly, a large diet and slimming industry exists in Western societies which makes a vast profit out of persuading people that slimness is a state that all people should aspire to. The contrasting images and values ascribed to fatness and thinness that are put forward in this industry's advertising is likely to have a strong influence on attitudes to fatness and fat people. Similarly, the relatively recent trend towards the adoption of fit, healthy lifestyles,

with the popularisation of sports activities such as jogging, aerobics and keep fit, has contibuted to particular attitudes towards fatness. Finally, and perhaps most importantly, attitudes towards bodyweight are likely to be influenced primarily by particular social and cultural factors. Such factors are likely to determine the types of bodyshape that are seen as desirable at any particular period of time and to provide the conditions that encourage the growth and perpetuation of such a bodyshape as the norm by institutions in society such as the medical profession and the beauty and fashion industries. I will now go on to review the literature relating to each of these factors and examine the types of attitudes that such factors encourage towards fatness and fat people and how and why these factors occur.

The medical profession has produced a substantial amount of literature concerning the definition, prevalence, health risks, causes and treatments of fatness. There is a consensus in the medical literature that being fat is an undesirable state from a health point of view. However, there is a considerable amount of conflicting evidence regarding the actual links between size and mortality and morbidity. It is widely held that there is a close association between mortality, in particular from heart disease and associated causes, and fatness (Berchfold et al, 1981; Stock and Rothwell, 1982). However, other research has shown that the relationship between fatness and heart disease is more complex and that a clear causal relationship is questionable (James, 1976; Andres, 1980; Brunzell, 1984). Some writers argue that mortality is significantly increased only in people who are 30-40% or more overweight (Wooley and Wooley, 1979). This group of very fat people are a very small percentage of those likely to be classified

as fat. As regards morbidity, there is general agreement in the literature that fat people are at greater risk from ill-health than their thinner counterparts. Diabetes, gallbladder disease, oesteoarthritis, hypertension, menstrual irregularities, infertility, obstetrical complications, surgery complications, psychological and social problems are all viewed as health complications associated with being fat (Abraham and Llewellyn-Jones, 1984). In the majority of cases, weight loss is viewed as beneficial in alleviating the conditions. The DHSS/MRC Report on obesity notes: 'We are unanimous in our belief that obesity is a hazard to health and a detriment to well-being. ... Many studies show excess mortality associated with obesity is reversible by weight reduction' (James, 1976:1,26).

Given that there is some consensus in the medical literature that fatness is a risk at least to morbidity, if not mortality, then the attitude of the medical profession towards fatness is that it is an undesirable state. This is likely to affect people's attitudes towards fatness and fat people in two ways: first, through the direct experience of fat people who come into contact with medical professionals and secondly, through a filtering down of medical views through the media. In terms of direct experience it sems likely that people who are viewed as fat by medical professionals will be given some advice about their weight and diet from such professionals. The likelihood of this occurring is indicated by the emphasis on treatment to be found in the medical literature (Foreyt, 1977; Munro, 1979; Royal College of Physicians, 1983; Craddock, 1989).

However, it is simplistic to assume that all fat people will receive advice and/or treatment from the medical professionals whom they

come into contact with or that all medical professionals view fatness in a similar, negative, way. There are several reasons for this. First, there is the difficulty in defining what constitutes 'fat'. Widespread agreement exists in the clinical literature with regard to the definition of fatness as an excess of body fat. However, the means of measuring this are varied and the point at which normal body fat ends and excess body fat begins is open to much individual interpretation on the part of doctors. The most commonly used forms of quick measurement are height-for-weight indices (Craddock, 1969; Blundell, 1979; Bjorntorp et al, 1981; Treharne, 1983) or the body mass index (Abraham and Llewellyn-Jones, 1984; Burton, 1985; Garrow, 1985). On the basis of these indices, a chart is used to define fatness. However, the point at which fatness is defined as beginning varies greatly (Munro, 1979; Garrow, 1981). This has been noted by Foreyt (1977:20) who asserts that there is 'no universal agreement' on the point at which a definition of fatness begins. It is only if people are defined as fat that they are likely to receive medical advice regarding their weight and the definition of fatness is subject to individual interpretation on the part of doctors.

The second reason why not all fat people will be viewed in a similar way or receive advice from medical professionals is related to the above point. This is that doctors, like all people, are individuals and therefore cannot be expected to behave or have attitudes that are uniform. Indeed, this can be seen to be the case in comparing the varying treatments that individuals may receive for the same condition from different doctors. An example of this can be seen with the treatment of patients presenting to their doctor with depression. Some

doctors may not recognise the condition at all and may refuse treatment, others may offer drug therapy while others may offer counselling. The treatment offered will depend on individual doctors' interpretation of the condition and their views on appropriate treatment. The same is likely to be true of fatness. Some doctors will identify this as a problem that needs treatment while others will not. In addition, the types of treatment offered will vary according to individual doctors' views on which treatments are the most effective (Allon, 1975).

Some of the feminist and fat liberationist literature that discusses the experience of fatness has indicated that comments, advice and treatments are fairly common experiences for fat people. It is not always clear in this literature what constitutes 'fat' and it may be that the people referred to are the very fat who were viewed medically as being at risk from ill-health because of their size. Nevertheless, it is noted in this literature that the attitude of medical professionals is that weight loss for fat people is always a desirable objective regardless of what the patient wants (Jenkins and Smith, 1987). In addition it is noted that fatness is commonly blamed for, or viewed as a contributory factor in, any illness that a fat person presents to their doctor for (Bovey, 1989; Greaves, 1990). As a result, it is argued, medical professionals that fat people come into contact with commonly comment negatively on fat people's weight and advise and cajole them in an attempt to persuade them to follow treatments that will lead to weight loss.

It is not clear from the literature whether it is common practice for fat people to be given advice or treatment from their doctors with a view to their losing weight. This may well occur for those who would be

viewed as very fat but for others this is likely to be very much dependent on the personal views of individual doctors. Nevertheless, it is argued that where this does occur, it has a significant effect on people's attitudes towards fatness. Fat people who are reminded every time they visit their G.P. that they should lose weight are likely to be unable to view their size in anything other than a negative light. Furthermore, fat people with past experiences of these practices by medical professionals will probably carry with them attitudes that fatness is an unpleasant and undesirable state.

The other way that the attitudes of the medical profession affect people's attitudes towards fatness is through a filtering down of medical views through the mass media. A number of trends have resulted in the views, attitudes and research findings of the medical profession becoming newsworthy items. Increasing medicalisation and the high status that has been afforded to medical opinion in recent years is one such trend, as is the rise in health education and the self-help health movement, the New Right stress on individual responsibility for health and welfare, and an increased interest in health and fitness amongst a substantial section of the population. Medical knowledge and opinion, then, are of interest to large numbers of people and the widespread reporting of health issues in newspapers, magazines and on television are evidence of this. However, the reports that are filtered down from the medical profession and reported in the media are aimed at a popular audience and, as a result, are popularised and summarised versions of medical knowledge and opinion which inevitably conceal the complexity of medical issues. The message passed on to people through the media reporting of medical knowledge and opinion is, then, simplistic and

often leads people to draw correspondingly simplistic conclusions regarding medical knowledge or opinion on a particular topic.

In relation to fatness, there is much media reporting of the medical profession's views on this subject. As with other health issues, the reports are often over-simplifications of medical views and opinions. Coward (1988) argues that the media commonly represent medical views of fatness as being that fatness is an intrinsically unhealthy state that the fat person should always make attempts to change. In addition, she observes that fatness is defined as being anything over the 'average' or 'desirable' weights set out in height-for-weight or body mass index tables (Coward, 1984). Some medical professionals may agree with this and may view and treat their 'fat' patients from this perspective. Indeed there is evidence from some of the feminist and fat liberationist literature that this is the case (Teddern, 1989). However, there is some consensus in the medical literature that it is chiefly people who are very fat who are at risk from ill-health and that the only clinical criterion for treating fatness is if illness is present or likely to occur if the level of fatness is maintained. Thus, the media's image of medical opinion on the subject, while it may not necessarily be different to individual doctors' practice, is an over-simplification of medical opinion and knowledge. It invariably presents fatness as being anything even slightly above 'average' weights and as a condition which is always unhealthy and which should always be changed whereas published medical opinion and research disputes this (Bjorntorp et al, 1981). Jenkins and Smith (1987) argue that the effect on people's attitudes of the media representation of medical views of fatness, as with that arising from

the negative experiences of fat people with medical professionals, is that fatness is viewed as an undesirable condition because of supposed links with ill-health. Furthermore, 'fatness' is not just a label reserved for very fat people but for anyone who exceeds the much publicised 'average' weights.

The second factor that has a strong influence on people's attitudes to fatness is the diet and slimming industry, and much of the feminist and fat liberationist literature has charted the rise of this industry. The diet and slimming industry is multinational and extremely profitable (Jenkins and Smith, 1987). Bovey (1989) argues that it grew out of the increasing idealisation of slimness which occurred as a result of the social, economic and cultural changes that began in the early 1960's and that it has had a significant impact on people's attitudes towards fatness.

Until the 1960's, diet and slimming were largely the preserve of medical practitioners. This was partly because slimness was not viewed as a cultural ideal at this time and consequently the label of fatness was generally applied only to very fat people who were likely to be at risk from ill-health because of their weight. In addition, popular methods of weight loss at that time included dieting pills (amphetemines) and diuretics which were available only on prescription and which could therefore be obtained only through doctors (Cline and Spender, 1987). However, the increasing emphasis on slimness that arose during the 'Twiggy' era of the 1960's resulted in the advent of a huge slimming industry which aimed to plug the gap in the market that the idealisation of slimness created.

The slimming industry concentrated its efforts in three areas: first, through slimming products such as low calorie foods; secondly, through slimming books containing advice on how to lose weight; and finally, through slimming clubs which gave more direct and personal advice on weight loss. It is noted that the focus on these three areas by the slimming industry has continued since the 1960's but their output has grown substantially over the years. Indeed, this can be seen by comparing the increase in the number and circulation of magazines devoted to slimming. In 1966 there were no slimming magazines in Britain but by 1986 there were ten. The combined circulation of the two slimming magazines which have survived since 1976 was just under 377,000 in 1976 compared with the combined circulation of seven of the ten slimming magazines available in 1986 which was just under 777,000 (Gilbert, 1989). In addition to magazines devoted exclusively to slimming and weight loss there has been an increasing trend to popular magazines containing advice and features about dieting (Parham et al, 1986). Indeed it is noted that such advice has a positive effect on magazine sales (Bovey, 1989). Comparative figures for the growth of slimming products, slimming books and slimming clubs are not readily available but there is a substantial literature indicating that their growth is indisputable. Gilbert (1989) notes that there are more than 230 books on diet and slimming currently in print and that in Britain nearly 100,000 people attend weekly meetings of slimming clubs. Furthermore, the popularity of fast weight-loss diets, such as the Cambridge Diet, which consist of meal replacement drinks have led to a high influx of such products onto the market (Bovey, 1989).

The reason for the market saturation of dieting products is undoubtedly financial. The slimming industry has capitalised on people's desire for slimness which has arisen from the cultural idealisation of this bodyshape and has made huge profits from it (Schoenfielder and Wieser 1983; Jenkins and Smith, 1987; Bovey, 1989; Greaves, 1990). It is argued that the effect of all this on people's attitudes to fatness is negative. The mass media's advertising of slimming products and their high coverage of dieting news and advice perpetuates the view that fatness is an undesirable state that can and should be changed. This has the effect not only of encouraging negative views of fatness in general but of encouraging people to view themselves as fat and to take action to lose weight. Gilbert (1989) notes that the number of people who see themselves as overweight is twice that of people who actually do weigh more than medically approved levels and that many of these people worry about their weight or have their lives restricted by it.

A parallel trend to the emphasis on slimness has been the emphasis on health and fitness. In recent years, health and fitness have become seen as desirable and obtainable goals for almost all individuals and have begun to cut across class and sex barriers to some extent (Coward, 1984). There has been a rapid increase in exercise classes such as keep-fit, aerobics and yoga, and more specialist forms of exercise, such as jogging and weight-training, which were previously the domain of the serious sportsperson are now popular pastimes for many people. There are several possible explanations for this emergent emphasis on health and fitness. Partly it may be a result of medicalisation and the high value put on positive health in recent years. An increased level of

health education is likely to have had an important part to play in this. On a more theoretical level, Turner (1982, 1984, 1987) has argued that the trend has arisen as a result of increasing standardisation of the body occurring as part of the process of rationalisation and decline in individuality symptomatic of late capitalism. It is not necessary here to debate the origins of this trend but sufficient merely to note its existence and its effects on people's attitudes to slimness. It is argued that good health in recent years has come to be equated with slimness (Coward, 1984; Cataldo, 1985). While fat people can be fit and healthy, fatness is not an image that is associated with health and fitness. Exercise is viewed as a way of achieving health and fitness through greater physical functioning of the body *and* slimness. The effect of the popularisation of health and fitness as desirable goals, then has been to further reinforce negative views of fatness because of its association with poor health.

The final area that has an influence on people's attitudes towards fatness is that of social and cultural factors. The trends outlined above: towards the medicalisation of fatness; to increased avaliability of slimming products and advice; and, to increased exercise, are not trends that exist outside of, and unrelated to, the culture in which they have grown. Indeed they could grow only in a culture where the conditions were ripe for such attitudes to flourish. Thus, these trends are the institutionalised views and attitudes that reflect those of our culture and society. It is noted in much of the literature, from various disciplines, that views about fatness are culturally and historically specific. In some cultures and in certain historical periods, to be fat is viewed as good because it denotes wealth and

success. At other times and places, fatness is equated with less desirable characteristics such as laziness and greed and to be fat is therefore not desired, or indeed socially acceptable. Allon (1975) argues that one of the major conditions determining cultural views of ideal bodysize is economic position. She notes that in economically poor societies where food is scarce, fatness is seen as a sign of success and prestige and it is only in societies which are economically rich and where there is an abundance of food that slimness is seen as an ideal. Several studies (for example, Bruch, 1974) reinforce this theory and have noted how particular cultures or sub-groups who have experienced severe food shortages in the past value fatness and view it as a positive attribute. Allon (1975:95-6) notes:

> 'In different times and in different places, people who have struggled to achieve the rewards of food, for whom the acquisition of food has been a problem, tend to praise fatness more than thinness. ... In contrast to the prestige of fatness in some societies, people who take for granted economic abundance in general, and food in particular, as a way of life tend to praise thinness more than fatness.'

It is argued that in western societies people have, since the 'Twiggy' era of the 1960's, been viewing large bodies as undesirable and socially unacceptable (Chernin, 1983). It is not clear precisely what caused the idealisation of slimness epitomised by the model, Twiggy, to arise with such suddenness and force and to survive for so long but her popularity marked a permanent end to the larger bodysizes popular during the 1950's. Allon (1975) argues that it is economic abundance and a puritanical reaction to affluence that have provided the conditions for anti-fat attitudes and institutions to grow. She argues that it is in countries with a strong protestant ethic and a preoccupation with guilt

and sin that a negative attitude to fatness is most likely to flourish. In common with Turner (1982), she also sees the standardisation of an ideal body size as a symptom of advanced social decay intrinsic to late capitalist societies. Following these arguments it may have been that thinness became popular during the 1960's as a reaction and backlash against the freedom, liberalism and affluence of this period. Whatever the causes, it is clear that a dislike of fatness and an idealisation of thinness is deeply entrenched in our society. If Allon's arguments are correct, it is an attitude that has grown out of our specific history and culture. Furthermore, it is reinforced by various institutions and groups that have a significant impact on forming people's attitudes in society. Thus, it is likely that the great majority of people will hold negative attitudes towards fatness. Indeed, this finding has emerged from the fat liberationist literature (Greaves, 1990). Furthermore, such negative attitudes towards fatness are likely to be very difficult to change (Wooley and Wooley, 1979).

1.2(ii) The Experience Of Fatness

Having examined the negative attitudes that exist towards fatness it is not difficult to predict what the experience of fatness might be like. Much of the clinical literature notes that fat people are viewed unfavourably and indeed are often ostracised because of their weight (Royal College of Physicians, 1983). However, it is the psychological, social-psychological and feminist literature that has given greatest prominence to this issue. In this literature, fatness is identified as a stigmatised condition. The concept of stigma refers to a 'relationship of devaluation in which one individual is disqualified from full social acceptance' (Mann, 1983:378). There is a considerable

amount of evidence to demonstrate that fat people are disqualified from full social acceptance and indeed are excluded from full participation in normal social life (DeJong, 1980; Bovey, 1989; Greaves, 1990). Many studies have found that fat people are viewed more negatively than slim people and that they have negative characteristics assigned to them on the basis of their appearance (Worsley, 1981; Harris, 1983; Harris et al, 1982, 1983). As a consequence of this, fat people have fewer personal relationships and are less likely to find a partner (Kallen and Doughty, 1984). Furthermore, it has been found that they are discriminated against in employment and in many areas of their daily lives (Candib Larkin and Pines, 1979; Benson et al, 1980). It is argued that buying clothes and using public amenities and transport are all difficult experiences for fat people to the extent that, in many cases, fat people have a very low participation in activities outside the home.

Fat people internalise the negative attitudes displayed towards them and as a result view themselves as deserving of public disapproval. On this point, Allon (1975) argues that fat people are multiply disadvantaged in that they are discriminated against and they are made to feel that they deserve this discrimination, and they come to accept this treatment as natural. She argues that these processes result in the fat person identifying and becoming identified merely as 'a fat person' and all other aspects of personality or identity are subsumed by this. Thus the fat person reaches the state of secondary deviation described by Rosenblum (1975). Wooley, Wooley and Dyrenforth (1979:83) in studying the negative attitudes of children to fatness note:

> 'The impact this hatred [of fatness] has on the individual child is probably irreversible. It is not only the obese child who suffers from this hatred: anti-fat attitudes learned in childhood no doubt become

> the basis for self-hatred among those who become overweight at later ages, and a source of anxiety and self-doubt for anyone fearful of becoming overweight.'

### 1.2(iii) Different Experiences Of Fatness Between Women And Men

So far I have not reported any differences identified in the literature between the experiences of fatness for women and men. However, there is a wide literature that notes that the experience of fatness between the sexes is very different. The literature suggests that women are more likely than men to perceive themselves as fat, to attempt weight loss themselves, and to have weight loss suggested to them by both the media and the medical profession. Furthermore, it is argued that being fat is a far more negative and stigmatised experience for women than it is for men.

There is clear evidence in all branches of the literature that more women than men perceive themselves as fat and make weight loss attempts. The British Medical Journal (1974), reviewing a study carried out in Richmond, found that almost all the overweight women in the study of all ages and social classes knew that they were overweight whereas 30-40% of the men in similar weight categories from all ages and social classes felt that their weight was suitable. Fewer than half of these men had ever tried to reduce their weight but almost 80% of the women had. However, it is not just women who would be defined as fat by some medical criteria who perceive themselves as such more readily than men. There is some evidence too that average weight women are far more likely than men to perceive themselves as fat. Gilbert, for example, notes that surveys have found that 'many people, women in particular, mistakenly believe themselves to be overweight, and that at least every

other woman who is not overweight has tried dieting' (Gilbert, 1989:6). This view is backed up by the Health and Lifestyles Survey which found that in the 18-39 age group, 40% of females who assessed their own weight as 'too heavy' were in fact within an acceptable weight range by medical criteia. By comparison, only 28% of men in the same weight category viewed themselves as 'too heavy' (Cox et al, 1987:127).

It is noted in much of the literature that one of the reasons why women, both those who are fat and those who are not, perceive themselves as fat and attempt weight loss more readily than men of similar weights is because of the attitudes of the media. The diet and slimming industry focus their advertising primarily, and indeed almost entirely, on women. While some dieting products may not be designed solely for women it is invariably a woman who is used to advertise the product (Jenkins and Smith, 1987). Similarly, it is more frequently women who are used in examples of 'before' and 'after' use of a diet or dieting product in advertising features (Greaves, 1990). In addition, popular magazines that are designed for a female readership frequently contain articles and information, as well as advertising, about dieting and weight loss. The same is not true for magazines that are aimed at a male readership. Bovey (1989) found a large percentage of magazines picked at random advertised articles about weight and dieting on their covers. Parham et al (1986) found that out of a total of 37 popular women's magazines available through newstands in America, only nine did not include articles or information about weight loss.

The use of women in the media, both in advertising and in plays and films, and the images that women are used to represent also perpetuates

the notion that fatness is a particularly undesirable state for women. Women are commonly used in advertising to sell a whole range of commodities from chocolates to cars. These women are portrayed as attractive and desirable and it is these attributes that advertisiers hope will encourage people to buy their products. Almost without exception such women are slim. Where fat women are used in advertising they are commonly used as a source of amusement or ridicle (Greaves, 1990). The same is true of actresses in plays and films. A survey of body types portrayed on television in 1978 found that fewer than 2% of actors were fat. Furthermore, youth, the female sex and positive personality attributes were all related to thinness (Gilbert, 1989). Wooley and Wooley (1979) report similar findings in their analysis of appearances of fat characters in the 30 most popular American television shows. They found that overweight females, but not males, were highly under-represented.

The focus on women by the diet and slimming industry and by the media, combined with media representations of slimness as an attractive and desirable attribute for women, is likely to be important in creating a climate which encourages fat women to view themselves, and be viewed, in a more negative light than fat men. It is argued in some of the fat liberationist and feminist literature that this climate of opinion affects medical professionals and that they are more likely to offer advice and/or treatment to fat women than fat men (Bovey, 1989). In a society as medically oriented as ours, it is the medical profession which has the power to set standards of normality in terms of weight. These standards that are set by the medical profession, it is argued, are not merely objective 'desirable' weights but reflect the cultural

and historical period in which doctors live and work. In our society, there is a cultural idealisation of slimness and an abhorrence of fatness and this is applied particularly to women. Doctors are subject to the same cultural norms as the rest of society and their practice and views are bound to represent those of their culture. There is a widespread view in the literature that doctors dislike fat people, that they prefer not to come into contact with them and that they apply negative characteristics to them (Allon, 1975; Bovey, 1989). It is also asserted that, given that the idealisation of slimness is aimed particularly at women, it is women who are more likely to be viewed as fat and treated for their fatness. It is clear that the great number of surgical procedures and drug therapies that are used as treatments for fatness are carried out on women, although this may be more a result of women seeking treatments rather than doctors offerring treatment more readily to women (Schoenfielder and Wieser, 1983). Nevertheless, the attitudes of doctors are clearly likely to represent those of the rest of society and, as such, are more likely to be condemnatory towards fat women than fat men.

Given that fatness is viewed as a much worse attribute for women than for men, it is hardly surprising that women experience fatness more negatively than men do. There is a wide literature from various disciplines noting that the stigmatisation of fatness is a particular problem for women and that they, rather than men, bear the brunt of exclusion and discrimination for being fat. Hillier (1981), for example, found that when students were asked to write stories about overweight and average weight people, they were more likely to ascribe unpleasant characters and write sad stories about the overweight,

particularly the overweight female. As well as being assigned unpleasant characteristics however, there is some evidence that fat women are actively discriminated against in the labour market and are excluded from full participation in society. Allon discusses a case where a woman was actually refused a job because of her weight and there is some evidence that this case is not an isolated incident (Allon, 1980). Brown (1977), in her study of 40 fat white American women, found that discrimination and exclusion from normal participation in society was a common experience for fat women. Buying clothes, eating in restaurants and using public transport were all identified as problematic activities for fat women. While such experiences may not be solely confined to fat women, Chernin (1983) argues that societal disapproval of fatness is aimed chiefly at them rather than at men. Wooley and Wooley (1979) too note this point and argue that it is women who are more affected than men by the prejudicial climate against fatness. Indeed, there has been a considerable amount of recent popular feminist literature that has stressed this point (Bovey, 1989; Greaves, 1990).

I have established that fatness is experienced more negatively by women than by men and that the pressure exerted by the diet and slimming industry, the media, and the medical profession accounts, at least in part, for this. I would now like to go on to examine why this situation has arisen. I have noted that the societal dislike of fatness is a cultural phenomenon and here I want to examine why this dislike should be centred so strongly on women rather than on men. To examine this it is necessary to discuss the feminist literature that has noted that the trend towards slimness as a cultural ideal is not something that affects

men and women equally and that this is linked to the emphasis that is placed on women's physical appearance.

It is argued that the process of socialisation that occurs in childhood, in the family and education system, and which is reinforced through adult experiences, forces females to view their appearance as being of primary importance but that the same is not true for men (Sharpe, 1976). The socialisation process, it is argued, ensures that boys and men view themselves as active participants in the social world whereas girls and women view themselves as passive recipients of others' actions. The focus on women's physical appearance is seen as crucial here in explaining these behaviours. It is noted that the emphasis on women's physical appearance that arises from their socialisation means that women learn that their appearance must always be given primary consideration. This consideration constrains their activities to a great degree and has been noted as one of the reasons why girls are reluctant to participate in subjects at school that involve wearing clothes or safety equipment that is viewed as unattractive and unfeminine or which involves getting dirty (Measor, 1983). Girls and women who do participate in such activities have been found to be characterised by both men and women as unfeminine and undesirable (Measor, 1983; Cunnison, 1989). The focus on women's physical appearance is not identified as the only factor explaining these behaviours. Nevertheless, it is viewed as an important explanatory variable and much of the literature notes a link between the focus on women's physical appearance and behaviour. For example, it is noted that much of the sexism that women experience in employment is related

to stereotypical views of femininity relating to appearance (Cunnison, 1989).

The theory of socialisation explains how the focus on women's physical appearance is perpetuated but in order to understand why this occurs the literature goes on to examine power relations between men and women. In examining this, the literature employs the concept of patriarchy. It is argued that society is patriarchal because men hold all major positions of power in society and consequently are able to define the roles that women can play (Eisenstein, 1984). There is a considerable amount of literature noting that the result of women's powerlessness in society is that they have to seek male approval. The need for male approval is seen as being both material and emotional. It is seen as material in that, because men hold positions of power in society, women have to seek male approval in order to gain access to material necessities and benefits (Sichtermann, 1986). Additionally, male approval is seen as necessary to women emotionally. This emotional 'need' for male approval occurs, it is argued, as a result of socialisation whereby women learn not only that they are inferior to men but also that they must exist to please men (Cline and Spender, 1987). 'Pleasing men' in this context means looking and behaving in a particular way and much of the literature notes that physical appearance is the primary way that women seek to gain male approval.

The reason why physical attractiveness has been elevated to this level of importance in gaining male approval is linked to sexual relations and it is argued that this reflects the power relations that exist between men and women (Greer, 1971). A substantial amount of literature argues that many women can feel positive about themselves

only if they gain male approval by conforming to male views of physical attractiveness and thereby being sexually desired by men. The actions of women surrounding this, it is argued, both signify and perpetuate women's oppression. They signify it by demonstrating that women's worth is linked to men's definitions and views of women as objects and it is perpetuated by women's constantly repeated actions in relation to their search for male approval (Eisenstein, 1984). While these actions are viewed as strongly correlated to women's oppression, however, it is noted that women have little choice but to pursue them because of the feelings of emotional security that are associated with gaining male approval (Coward, 1984). Additionally, it is noted that where women do not conform to this pattern of behaviour in seeking male approval, sanctions from men frequently occur (Greer, 1971; Cline and Spender, 1987).

This feminist literature, then, focusses on the view that physical appearance in terms of attractiveness is of crucial importance for women and that this is illustrative of women's oppression. The literature also discusses how definitions of attractiveness for women emerge and how, contemporarily, slimness has become part of this definition. It is argued that while notions of beauty and attractiveness are relative concepts, they are not merely a matter of individual taste. Rather, it is argued, such notions are subject to social influences and, because we live in a patriarchal society, these inevitably 'mirror the dreams and wishes of men' (Sichtermann, 1986:44). Writers such as Coward (1984) argue that this occurs because men hold positions of power in society and control the visual media through which they propagate male-defined images of how women should look. The images that correspond to notions

of attractiveness at any given time, therefore, reflect the roles and images that men have allocated to women at that time. For example, the post-war image of attractiveness for women was one of sensuality, softness and passivity as epitomised by 'sex-symbols' like Marilyn Monroe. This image of attractiveness, it is argued, became dominant as a move against the wave of emancipation that occured in women's lives during the second world war when many women entered the labour market and had their lives transformed as a result (Sichtermann, 1986). The emergence of the soft, sensual, sexual woman as the ideal of attractiveness can be seen, then, as part of the general promotion of women's domesticity in the post-war period (Minns, 1980).

It is argued that, as women's lives and roles have changed, so too has the ideal of attractiveness. Today's ideal of attractiveness for women has changed from being curvy and cuddly to being slim and athletic. This change, it is argued, reflects the changes that have occured in women's lives as women have gained greater independence through participation in the public sphere. However, such changes have not brought women greater power and the image of attractiveness for women reflects this. There is consensus in the literature that the current idealised image of attractiveness is one of a slimness that is associated with adolescence and immaturity (Chernin, 1983; Coward, 1984; Sichtermann, 1986). It is, therefore, not an image that carries any connotations of power but one that is 'a modern variant of feminine passivity' (Coward, 1984:41) and as such reflects women's contemporary position of powerlessness.

Thus, it is argued that the current equation of slimness with attractiveness for women amounts to a cultural ideal so that all women

feel that to be attractive they must be slim. Much of the literature notes the lengths to which women go to achieve this ideal body shape and the feelings of low self-esteem and worthlessness that result from a failure to achieve this goal. One of Cline and Spender's interviewees sums this up:

> 'The worst thing you can be as a woman is fat ... because men won't like you. And if it is a woman's purpose in life to be liked by men, then to be fat is to forego one of life's essential ingredients. It is to fail to meet the mark of male approval and acceptance'.
> (Cline and Spender, 1987:80).

The general literature on fatness has identified fatness as a particularly negative experience for women and the feminist literature has reinforced this by illustrating the importance of slimness for women's self-esteem. Furthermore, this literature has put forward explanations for why women, rather than men, should be the focus of the cultural dislike of fatness prevalent in our society. It is argued that women are defined by their physical appearance in a way that men are not, and that this accounts for the pressure that is exerted on women to be slim.

As I noted above, there has been no sociological work directly concerned with examining fatness. Given the identification in other literature that this is a gender-divided experience and one that may be explained by the patriarchal nature of society, this is an important yet neglected topic. Examining the social experience of fatness and the various ways that women experience and interpret negative attitudes to their weight are important areas of study and ones that are pursued in this research. Furthermore, the extent to which feminist analyses provide adequate explanations for the negative experiences of fat women

need to be examined. However, it is not just the experience of fatness that is under study here. It is fairly clear from the literature that fat women have a very negative experience of their fatness. Of interest here is whether there is any potential for women's fatness to be viewed and/or experienced in a more positive light at certain points in their lives. The period I want to examine here is that of pregnancy because pregnancy is a period when women are expected to put on weight and to appear, to some degree, fat. Thus, I want to examine whether fat women experience their weight and size differently during this period and whether any changes are temporary (lasting only for the duration of the pregnancy) or whether they can survive into the post-pregnancy period and beyond.

1.2(iv) <u>The Experience Of Fatness During Pregnancy</u>

There is some evidence, albeit limited, that the strong social pressure on women to be slim is relaxed to some degree during pregnancy. The feminist literature argues that fat women feel dissatisfied with their weight because they do not conform to the cultural ideal of slimness and that this is experienced more negatively by women because in a patriarchal society women are judged on the basis of their physical appearance. However, there is some literature that notes that during pregnancy women are not judged by their physical appearance in the same way. There is a varied literature from the field of sociology and psychology, as well as from the more popular writings on women's health and pregnancy in general, that has noted that women are viewed and treated differently during pregnancy than they are at any other time. In terms of the way that women are perceived during pregnancy, Price (1988:32), for example, notes that there is a shift away from women

being viewed as 'seducers' to being viewed as 'producers'. Charles and Kerr (1986a:554) too note this shift in women's body image during pregnancy which they refer to as a move from women's bodies being viewed as 'ornaments' to their bodies being viewed as 'functional'. Additionally it is noted that this different view of women during pregnancy also affects the way that they are treated. It is argued that pregnancy carries with it greater social status and is a condition that elicits respect from men and women alike. The result of this elevated social status and the downplaying of emphasis on pregnant women's sexuality and physical appearance is that pregnant women tend to be pampered and cared for to some degree (Graham, 1976; Price, 1988). The shift identified by this literature, then, is that during pregnancy women are not defined by their appearance and their bodies are not viewed as sexual in the way that they are at other times; rather they are defined by the fact of their pregnancies and their bodies are viewed as productive.

As well as the downplaying of emphasis on women's physical appearance, pregnancy is also a time when it is acceptable and even expected that women will be fat, at least to some degree. Weight gain is inevitable and desirable during pregnancy. The clinical literature notes that an average and desirable weight gain throughout an entire pregnancy would be about 12.5kg. (Munro, 1979; Gillmer, 1982; Drife, 1986). There would be some concern if women, starting off pregnancy from an average weight, gained substantially less than this amount during pregnancy. Thus, pregnancy is probably the one time during most women's lives when weight gain is expected and desired both by themselves and by

others. There is no literature that focusses specifically on women's feelings about their body image in terms of their size during pregnancy although there is some literature that has paid passing attention to this topic. The limited literature that there is indicates that pregnancy may be a time when fat women could experience their weight in a less negative way, both in terms of their feelings about themselves and the attitudes of others, due to a greater social acceptability of fatness during pregnancy (Breen, 1981; Orbach, 1984). One of Orbach's clients illustrates this: 'Having a tummy was for the first time legitimate and praised. People used different words to describe these body changes than those associated with fatness. They effortlessly found ways to compliment the new growth, thus giving lie to the 'fact' that only slimness can be beautiful' (Orbach, 1984:73).

However, while pregnancy may be a period when the focus on slimness for women is relaxed socially there is evidence of a different attitude from the medical profession. I noted above that the medical profession's attitude to fatness in general mirrors that of society. However, during pregnancy this changes. While society appears to relax its attitudes towards women's bodysize during pregnancy in that, for example, fat pregnant women are not used in advertising material for weight loss products, the medical profession do not relax their concern with fatness during pregnancy. Indeed there is a substantial medical literature focussing on the topic of fatness and pregnancy.

As with the medical concern with fatness in general, the reason for the medical profession's concern with fatness in pregnancy is that there are seen to be health risks associated with this condition. The existence of health risks is disputed in some of the feminist and fat

liberationist literature which argues that such risks have been over-emphasised by the medical profession because of a general abhorrence of fatness (Schoenfielder and Wieser, 1983). However, there is a considerable amount of clinical literature noting that many health risks for both mother and baby are associated with high maternal weight in pregnancy. There is some variation in the literature regarding the incidence and severity of health risks, but there is, nevertheless, some consensus that significant health risks do exist. The medical studies that have examined the health risks associated with fatness in pregnancy are hard to compare because of the different types of definition and grades of fatness that are used. However, the great majority of studies of both moderately and very fat women note an increased risk of hypertensive disorders, pre-eclampsia and diabetes mellitus in pregnancy (Gross et al, 1980; Garrow, 1981; Campbell and Gillmer, 1982; Kliegman and Gross, 1985; Abrams and Parker, 1988). In addition, some studies note an increased risk of urinary tract infections (Garbaciak et al, 1985), of varicose veins (Ruge and Andersen, 1985) and of inadequate weight gain in pregnancy (Harrison et al, 1980; Abrams, 1986). Problems in labour and delivery are also noted in the majority of studies and this, in conjunction with ante-natal complications and the incidence of large babies, means that fat women often have caesarian sections (Garbaciak et al, 1985). This operation carrries its own risks but these are more acute for fat women because of the complications associated with anaesthesia and surgery for this group (Hodgkinson and Hussain, 1981; Wolfe et al, 1988).

As with the definition of fatness, the definition of fatness in pregnancy, and consequently the point at which health risks are viewed

as beginning, is open to much individual interpretation on the part of medical professionals. Thus, pregnant women of varying weights are likely to be classified as fat and be given advice and/or treatment according to their doctor's individual views on the subject. In the medical studies of fatness in pregnancy, the attainment of the weight of 90 kg. sometime during pregnancy is often used as a definition. The weight of 90 kg. is used because it is viewed as a 'critical' weight that is associated with a significant number of medical problems (Gross et al, 1980; Kliegman and Gross, 1985). Other studies use recollected or estimated pre-pregnancy weights and then compare these to height-for-weight indices to classify fatness (Hytten and Leitch, 1971). Again, there is variation from doctor to doctor concerning the point above indices' standard weights that fatness is held to begin (Walker et al, 1976; Harrison et al, 1980; Haworth et al, 1980; Studd, 1984; Abrams and Laros, 1986). However, while there is little agreement on the definition of fatness in pregnancy, all the definitions imply that for a woman to be classified as fat during pregnancy she would be likely to be classified as fat before pregnancy or to have a very large weight gain during her pregnancy.

The clinical literature also discusses treatment for fat women in pregnancy although, again, there is little consensus on this. Some literature notes that low carbohydrate diets should be advised for fat women during pregnancy and that these have no ill effects on the mother and baby (Craddock, 1969; Munro, 1979; Garrow, 1981). Other literature notes, however, that low carbohydrate diets should not be used but that some form of less extreme food restriction is still advisable for fat pregnant women (Gillmer, 1982). Some literature notes that any form of

dietary restriction at any point during pregnancy can result in nutritional deficiencies and be dangerous to both mother and baby and therefore should not be used at all (Greenhill, 1974; Drife, 1986). There is, then, little consensus on treatment for fat women who are pregnant. The sort of advice fat women receive in pregnancy is likely to vary from doctor to doctor and to depend on individual doctors' (and other medical professionals') views regarding this.

The evidence from the medical literature implies that fatness during pregnancy is viewed as an undesirable condition in much the same way as fatness in general is. However, unlike the general state of fatness, the medical view of fatness in pregnancy appears not to be mirrored in general social attitudes of other groups and institutions in society. What impact this has on fat women's feelings about their weight during pregnancy is not clear and has not been the subject of academic study. It may be that fat women experience their size in a more positive light during pregnancy because their size is viewed by themselves, and by others, as more socially acceptable. However, comments or advice to lose weight by medical professionals may negate more positive feelings about their size and may lead to the reassertion of negative feelings. Feelings about the pregnancy too may impinge on fat women's feelings about their weight, particularly if they are told that their weight may pose some health risks to their baby. The feelings that fat women have about their weight during pregnancy, the factors that influence these feelings, the changes that occur from a pre-pregnancy state and the extent to which changes survive into post-pregnancy will be key foci in this research.

## 1.3 EATING BEHAVIOUR

As I noted at the beginning of this chapter, a study of fat women's feelings and experiences regarding their weight cannot be carried out without an examination of eating behaviour, as this is seen both medically and popularly as a major cause of, and cure for, fatness. The popular association of eating behaviour with fatness is beyond question. There is a popular conception that over-eating, particularly of 'fattening' foods such as chocolate, will cause fatness and that fat people are fat because they over-eat (Jenkins and Smith, 1987; Gilbert, 1989; Teddern, 1989). Greaves (1990:16) notes that 'the assumption which links food consumption with body size is widespread, ... large people are generally stereotyped as being greedy ... as having no control over their eating habits'. Much of the literature notes that this is not necessarily a correct assumption and that 'while some of them [fat people] do indeed eat compulsively, or inappropriately, that does not mean to say that all large people do' (Greaves, 1990:16). It is argued in this literature that individual metabolism is a more adequate explanation for fatness in some cases. However, whatever the cause of fatness, the popular notion is that fat people should always want a 'cure' for their fatness, that is to become slim, and that the cure is a change in eating habits in some way. Evidence of this is the media's presentation of food reduction as a cure for fatness and the great number of dieting attempts that fat people, particularly fat women, embark on.

In terms of the medical literature, much of this notes that fatness is multi-causal. Bruch (1974), for example, notes that people who are classified as fat become fat for a variety of different reasons and it

is impossible to assign single causes uniformly to all fat people. It is noted that some people become fat as a result of a particular illness or because of side-effects of drugs. Among other physiological causes, hypothalmic injury, endocrine imbalances and genetic and metablolic factors are viewed as important. However, the majority of explanations of fatness involve diet or eating in some way. Many explanations stress psychological or social factors that lead to overeating although not all explanations stress over-eating as a cause for fatness. Some literature notes that for some fat people their metabolism is such that they have low energy requirements and are therefore likely to become fat on relatively small amounts of food (Wooley and Wooley, 1979). Nevertheless, in the medical literature, diet and eating in some form are seen as explanations for fatness in the majority of cases and therefore as a potential cure.

As well as the medical literature, there is literature from the fields of psychology, social-psychology and feminism that has examined the issue of fatness and its causes. All this literature focusses exclusively on eating as explanations for fatness and much of it sees the problem as one of over-eating. Unlike the medical literature, much of this literature focusses on women and examines why fatness and eating problems might be particular problems for them. In addition, there is some literature from the sociology of food and eating which identifies possible causes of fatness related to women's roles as preparers and servers of food in households. I will now go on to review the literature from the various fields which identifies explanations for fatness that are related to eating and particularly those that are

specifically relevant to women. The purpose of this is to identify why women might become fat in the first place and the potential that exists for changing their bodysize. Following on from this I will go on to discuss what changes to this state might be brought about by pregnancy and whether such changes might survive after pregnancy.

1.3(i) Causes Of Fatness

One explanation for fatness that is referred to in the medical literature and examined in depth in the psychology literature is that fat people have different eating behaviours than slimmer people. Some of this literature has examined how particular social and environmental factors may influence the types and amounts of food that are eaten (Rodin, 1980). It is noted that there are particular 'cues' which determine eating patterns, so that what, where, when and how much food is eaten can depend on such factors as time of day, situations, convenience and food availability. However, while these cues are seen as being culturally specific, the literature holds that they do not affect all members of a population equally. It is suggested that fat people respond more readily than average weight people to social and environmental cues to eat and that this can explain their fatness. There is an extensive literature examining the responses to food cues made by fat people (Blundell, 1979; Lowe and Fisher, 1983; Slochower, 1983). No clear causal relationship between responsiveness to eating cues and fatness has been found. In fact Rodin (1980) notes that people in all weight categories can be highly responsive to food cues. However social and environmental factors are nevertheless viewed as important in predisposing a person to fatness, especially where an abundant supply of food is readily available.

An inter-related area in this literature is the study of the eating behaviour of fat people. In this field of research it is hypothesised that fat people have distinctive eating behaviours that explain their size. Research in this field has concentrated on two issues. First, an examination of food choices, where it is hypothesised that fat people choose to eat different sorts of foods to average weight people and secondly, an examination of eating styles, where it is hypothesised that fat people may eat faster than average weight people. Again, there have been several studies in this area with no clear agreement about a distinctive eating behaviour of fat people emerging (Drewnowski, 1985).

Some of the medical literature has identified deeper psychological explantions for fatness. For example, the importance of the role of parents in determining eating patterns is acknowledged. The DHSS/MRC Report, for example, notes 'Some households appear to be very preoccupied with food, and some mothers use food as a method for pacifying children. The child is thereby taught to recognise food as a means of reducing anxiety' (James, 1976:17). While the report notes that the extent to which this is associated with fatness has not been subject to 'sound scientific study' (James, 1976:17), other literature, particularly from the field of psychology, takes this to be a significant cause of fatness. Some of this literature argues that inappropriate learned behaviour in childhood is a significant cause of fatness. One of the explanations given is that fatness occurs when a child fails to learn correct hunger awareness and, as a consequence, eats greater amounts and more often than s/he physically needs to (Bruch, 1974). In this literature it is held that hunger awareness is a learnt form of behaviour and a child who is fed when s/he cries for food

learns the appropriate feelings associated with hunger and fullness. In contrast, a child who is fed for comfort or reward, or who has food withheld for punishment does not learn to interpret feelings of hunger awareness appropriately and will grow up without being able to differentiate between various biological and emotional needs. Such a child is likely to eat, or indeed to over-eat, when s/he is not physically hungry as a response to emotional needs and therefore to become fat. This type of fatness is termed by Bruch (1974) as 'developmental' and she notes that severe emotional and personality disorders are also likely to be present because of the person's inability to develop an awareness of her or his individual needs.

An additional psychological factor acknowledged in the medical literature is that linking emotional stress with fatness (Lipinski, 1975; Bradley, 1985; Van Strien et al, 1986; Rookus et al, 1988). It is asserted that some people eat in response to the stresses that they encounter in their lives, and as a result become fat. These stresses may be big, such as a loss or a bereavement, or minor stresses that are encountered daily at work or at home. Food is used as a source of comfort and as a way of relieving such stresses in much the same way as some people use alcohol or tobacco. It is argued that people who use food in this way tend not to get angry or depressed as the eating appears to ward off such feelings. There has been a steady stream of research examining the phenomenon of stress-eating since Newburgh's first study in 1931. Bruch, among others, has identified this pattern of eating as being a significant cause of fatness and has called it 'reactive' (Bruch, 1974).

The psychological and social-psychological literature gives particular prominence to stress-eating referred to in the medical literature. People who eat when under stress are classified in much of this literature as compulsive eaters. The medical literature gives some prominence to this definition, but its greatest usage is in the feminist, psychological and social-psychological literature (Orbach, 1978, 1984). There are varying definitions of what constitutes compulsive eating. Some studies define a compulsive eater as someone who uses food emotionally in the way that a stress-eater does (Lippincott, 1965). Others use a more clinical definition and define it as a definite eating disorder which involves having irregular and unpredictable eating binges which may last for hours or even days and which are followed by feelings of guilt and shame (Rau and Green, 1975; Abraham and Llewellyn-Jones, 1984). Nevertheless, there are two distinct similarities in the majority of definitions of compulsive eaters that are used. First, they are viewed as eating when not physically hungry and secondly, as feeling out of control with food. It should be noted here that not all people who are compulsive eaters are necessarily fat. Some people may follow a compulsive eating bout with strict dieting, or indeed may be bulimics who use laxatives or induce vomiting to keep within their normal weight range (Orford, 1985). Nevertheless, compulsive eating is a condition which can lead to fatnesss and is thus a potential explanation.

The majority of possible causes of fatness are not viewed as being any more likely to affect men more than women or vice versa. However, in the case of compulsive eating or stress eating this changes dramatically. Compulsive or stress eating is seen as a condition that

affects many women but is a relatively rare condition in men (Orbach, 1978; Chernin, 1983). There are several reasons given in the literature for why this might be so. These are discusssed most thoroughly in the feminist literature, although they are also mentioned in some of the social-psychological literature (Roth, 1982; Melville, 1983; Lawrence, 1987). The major reasons are seen as relating to women's social roles which, it is argued, are inherently stressful because of their restrictive nature. It is held that female children born and brought up in a Western culture have their personal development restricted and controlled through the process of socialisation which prepares them for their adult female roles. These adult roles involve the relationship of marriage (or a similar relationship) and motherhood which the majority of women enter into. The female roles that accompany this set of relationships are viewed as particularly harmful, both personally and emotionally, because of the constraints, monotony and stress that they engender.

Alongside the wife and mother roles, the process of socialisation also encourages girls and women to become obsessed with their physical appearance and to conform to a narrow stereotype of attractiveness, as has already been discussed. The emphasis on women's physical appearance and the pressure to conform to a particular stereotype of feminine beauty is viewed by the literature as an additional stress experienced by women (McBride, 1982). It is noted by Orbach (1978, 1984), among others, that these stresses inherent in women's social roles encourage many women to become compulsive eaters. It is argued that compulsive eating is a way both of rejecting and of coping with the dissatisfaction experienced in these roles. Thus, women may eat compulsively in order

to put on weight in an unconscious attempt to reject the stereotype of femininity and womanhood; both in terms of the appearance a woman is expected to have and the role she is supposed to enact. Compulsive eating may also act as a coping mechanism, first, as a way of suppressing anger and secondly, as a way of helping women to cope with the emotional needs of others for whom their roles make them responsible (see Orbach, 1978; McBride, 1982; Chernin, 1983).

Another explanation for fatness in women that is related to their socialisation is put forward in the feminist and social-psychological literature and is noted in some medical literature. It is argued that the social pressure on women to conform to a particular bodysize results in constant dieting by some women and that this actually causes fatness through the metabolic changes it brings about (Schoenfielder and Wieser, 1983; Gilbert, 1989). It is noted that the pressure for women to be slim is very strong but that very few women conform naturally to this ideal (Cataldo, 1985). A huge slimming industry centred on women encourages them to diet but while diets are often initially successful for many people, long-term weight loss maintenance is much less so, and it is this factor that is seen as important in causing fatness. There is a high failure rate for long-term weight loss maintenance and so many women go through cycles of dieting followed by weight gain followed by more dieting, and so on. This cycle of behaviour is seen to cause fatness because the body tends to conserve energy during times of shortage (dieting) and thus when normal eating patterns are resumed the person is likely to become heavier than before. As Wooley and Wooley note, 'Dieting reduces metabolic rate and caloric expenditure during activity, and some of these functions may not recover immediately with

refeeding ... It seems possible that nature may have equipped us with adaptive mechanisms to conserve calories when food shortages occur without means for complete reversal of this adaptation' (Wooley and Wooley, 1979:73). Thus it is argued that the process of dieting may actually be a major cause of fatness, particularly among women.

Some of the medical, psychological, social-psychological and feminist literature notes that social and cultural norms of behaviour relating to food may account for particular groups of the population, among them women, becoming fat (Orbach, 1978; Royal College of Physicians, 1983). It is argued, for example, that working-class people are more likely to be fat than middle-class people for several reasons (Silverstone, 1975; Power and Moynihan, 1988). First, health education regarding diet and exercise is not aimed specifically at, or made accessible to, working-class people. Secondly, healthy, less-fattening foods, such as fresh fruit and vegetables, tend to be expensive and people at the lower end of the income scale are less likely to be able to afford them. Furthermore, 'healthy' foods tend to take longer to prepare and working-class people often have neither the time nor the energy for this and thus may opt for quick 'convenience' foods instead. Thirdly, regular physical exercise has tended, in recent years, to become more sports-club based and again issues of time, money and energy can explain why working-class people tend to enjoy such physical leisure pursuits less. These arguments are backed up by some sociological literature which has noted that working-class people often consume diets that are proportionally higher in carbohydrate and lower in protein than middle-class people and therefore that working-class people are more likely to become fat as a result (Orr, 1936; Blaxter, 1983a, 1983b;

Murcott, 1983; Lang et al, 1984). The Health and Lifestyle Survey (Cox, 1987), for example, noted that working-class people were more likely to eat white bread than brown and to have a low consumption of fruit and salads and a high consumption of fat. Graham too notes this:

> 'Average individual consumption of 'good food' - particularly of meat and fresh fruit and vegetables - is significantly higher in high-income households. Conversely, individual consumption of carbohydrates is significantly lower, with low-income families eating twice as much white bread per head as high-income families ... Poorer families tend to have diets higher in calories ... [but] lower in quality'
> (Graham, 1984a:124).

This literature suggests that working-class women may be more likely than middle-class women to be fat, and income as well as cultural food habits and beliefs relating to the types and amounts of foods that are eaten are seen as explanations for this.

There is also some reference made in the literature to women being specifically prone to becoming fat as a result of social and cultural norms of behaviour relating to women's social roles in connection with food. This explanation is noted in all the fields of literature although it is most thoroughly documented in literature from the sociology of food and eating (Royal College of Physicians, 1983; McBride, 1982; Orbach, 1978; Charles and Kerr 1986b, 1988). In this literature it is argued that through their social roles, women are generally seen as having primary responsibility for the buying, cooking and serving of food. This means that temptations to eat are always at hand. In the kitchen, women tend to have lots of 'tasters' of the food that they are preparing without really being aware of it and throughout the day this may add up to a substantial amount. Furthermore, it has been noted that many women tend to finish food left by the rest of the

family that would otherwise be thrown away. Charles and Kerr (1988) go on from this to argue that women's relationship with food is problematic because they are expected to devote a lot of time to providing healthy and enjoyable food for the family, but at the same time are expected to deny themselves food in order to remain slim and thus sexually attractive. This, they argue, is a constant problem for women and, because food can act as a comfort at times of emotional stress, many women experience weight problems and eating disorders as a result of this contradictory relationship with food.

The sociology literature has also noted some of the social factors which determine patterns of food purchasing, preparations and eating and while these are not identified in the literature as explanation for fatness in women, they nevertheless do stand as potential explanations. The major point emerging from the literature is that there is an ideology that surrounds food and eating which is a familial one that both reflects and reinforces the sexual division of labour and patriarchal power relations (Charles and Kerr, 1988). This ideology is seen as evident in the cultural customs and practices which, to a large degree, determine what food is eaten, who prepares and serves it, and how, where and when it is eaten.

The customs and practices surrounding food and eating in families identified in the literature centre around three points. First, a 'proper' meal is one where the whole family is present; on weekdays this is usually an early evening meal and at weekends a midday meal, and is ideally a meal that is eaten sitting around a table. Furthermore, this 'proper' meal comprises meat, potatoes and vegetables followed by a dessert (Murcott, 1982a; Charles and Kerr, 1986b). Secondly, during

these family mealtimes certain forms of behaviour set out by the male 'head' of household are expected from family members, and children may be punished by him if these are not followed (Charles and Kerr, 1988). Thirdly, the meals are prepared and served by the adult female of the household and the particular foods that are cooked reflect the food preferences of the male. Furthermore, the male is 'privileged' in terms of quality and quantity of food ahead of first, the children of the household and second, his female partner (Charles and Kerr, 1986a). While there may be differences in degree to which these customs and practices exist in families, it is argued that they form the basis of all family mealtimes regardless of class divisions. Such practices do not necessarily lead to fatness for women, and indeed are not identified in the literature as doing so. Nevertheless, it is possible that fatness could result from women having to participate in 'family' mealtimes and having to cook and eat foods that are chosen by their partners.

This concludes the various explanations given in the literature for fatness in general, and specifically fatness in women. The explanations are varied and are not viewed as mutually exclusive or as applicable to all fat people. It is noted that no single cause to explain all fatness exists, but rather that there are a number of possible causes that may affect an individual singly or multiply. The explanations that I have discussed here have been that fatness is a result of: a different eating behaviour from slim people; of poor learning of hunger awareness as a child; of a constant cycle of dieting; a reaction against stress which may be particularly applicable to women; and of women's social roles as preparers and servers of food in the home. An examination of the

relevance of these explanations in the context of women who actually experience the condition is important especially given the lack of academic literature on the topic from this perspective. It may be that some explanations are more or less relevant for some women and their attitudes to, and their feelings about, their weight may be affected by the factors that have led to them becoming fat in the first place. Furthermore, an examination of these explanations is important in terms of looking at the potential for fat women changing and becoming slim. It is clear from the literature that the majority of fat women would prefer to be slim but the literature discussed above demonstrates that whatever the underlying cause, or group of causes, a change in diet or eating behaviour to bring about slimness is likely to be very difficult to bring about. This may be particularly so for women given the evidence from sociological literature for the existence of an entrenched ideology surrounding food and eating practices within households and perhaps even more so for working-class women given the economic constraints discussed in the literature.

1.3(ii) Eating Behaviour During Pregnancy

I have reviewed the literature which has examined possible explanations, relating to eating behaviour, why women might become fat in the first place. I will now go on to discuss the changes that can take place in eating behaviour during pregnancy. Such changes are important in that they affect weight and may similarly affect a woman's feelings about her bodysize.

Most of the medical literature does not discuss changes in eating behaviour during pregnancy, or where it does, it does not examine why these changes might occur. Most of the clinical literature that

discusses significantly larger than average weight gains during pregnancy appears to view these as caused by physiological problems, such as fluid retention (Iffy and Kaminetzky, 1981), or because the woman is merely overeating. This latter assumption on the part of medical professionals can be seen by the types of simple dietary advice and treatment that fat women are given during pregnancy. While both these factors are certainly potential explanations for large weight gains in pregnancy they may, in some instances, be only partial explanations. In terms of the overeating explanation, it is not enough to say that some women who are fat during pregnancy overeat or eat the wrong types of food without questioning, as the more general literature on fatness has, why this type of behaviour might occur. Similarly, it is important to examine why some women who are fat before pregnancy put on a lot of weight during pregnancy whereas other women of a comparable starting weight do not. Some of the psychological literature has examined these areas and has identified social and psychological factors as important in encouraging women to overeat, thereby contributing to their being fat or becoming fatter during pregnancy.

In this literature it is noted that some women eat excessively during pregnancy (and therefore become fat or fatter) as a way of psychologically rejecting pregnancy and motherhood. Literature from the field of psychology, and in particular from the psychoanalytic school, argues that women have an innate, instinctual desire to become pregnant, give birth and care for children, and that this is an integral part of the process of achieving mature womanhood. Sandler, for example, writes: 'What determines the achievement of adult femininity? There must be full acceptance of the feminine role with self-love and self-

approval ... parental example should lead to acceptance of and eager anticipation of marriage, pregnancy and motherhood as natural, normal and desirable events for the future' (Sandler, 1978:37). It is argued that the absence of the desire to have and care for children, or the experience of dissatisfaction with these events, is indicative of developmental problems and poor adjustment to feminine psychosexual identity (see the discussion in Boulton, 1983). Some of the psychology literature concerned with eating disorders notes that women with such developmental problems may eat excessively upon becoming pregnant as a way of rejecting pregnancy and the 'mature maternal role' (Bruch, 1974). In such cases, Bruch notes, the woman is unable to accept the roles and responsibilities that pregnancy and motherhood thrusts upon her and her reaction of turning to food demonstrates her unspoken desire of wanting to remain a child herself.

Some social-psychological, feminist and sociological literature, however, has gone on from these assertions and noted that dissatisfactions with pregnancy and motherhood do not occur only in a few individual women with psychological problems. On the contrary, they argue that it has been found that it is commonplace for women to experience dissatisfaction with these events. While there is no reported incidence of a lack of desire on the part of women to have children, there does appear to be evidence of ambivalent feelings and dissatisfactions with this experience, and this has been found to be more the norm than the 'acceptance and eager anticipation' that some psychology literature suggests is normal.

One of the major findings of the substantial sociological literature on pregnancy, childbirth and motherhood has been to identify the dissatisfactions that many women experience with these events (Graham, 1977; Oakley, 1980, 1986; Breen, 1981; Ball, 1987; Price, 1988; Martin, 1989). In terms of pregnancy, a number of studies have found that this is a time beset with anxiety and feelings of ambivalence. Graham (1977) found that such anxieties during pregnancy were shared by women irrespective of other differences such as planning and number of previous pregnancies. In studies of pregnancy, respondents have reported a desire to escape from pregnancy, feelings of hostility towards the unborn baby and anxieties about impending motherhood. Additionally, it is noted that the realities and expectations of pregnancy are very different. Price (1988), for example, notes that the physiological problems in pregnancy are often greater than women anticipate and, furthermore, that psychologically women experience unexpected feelings and anxieties. Oakley's extensive study of first time pregnancy, childbirth and motherhood is instructive in relation to these points (Oakley, 1980, 1986a). She found that at the beginning of pregnancy, even when a baby is plannned and wanted, many women experience mixed feelings. She noted that although women are expected to be 'overjoyed' at the prospect of pregnancy and childbirth, in fact worries about the birth, the health of the baby, getting fat, giving up work and changes in life-style were all common preoccupations of the pregnant women in her study. In interviews taking place at a late stage of pregnancy, she found that more than one third of her sample of women viewed pregnancy as being worse than they had expected.

The event of childbirth too is identified in the literature as an event that many women report dissatisfaction with. Furthermore, a negative experience of childbirth has been identified as an important factor contributing to post-natal depression and there is a considerable amount of literature focussing on this aspect of childbirth (Oakley, 1980; Breen, 1981; Price, 1988; Martin, 1989). In this literature it is noted that modern technological methods of childbirth have led to women feeling that they have no control over the birth of their baby. It is argued that the more medically inteventionist the birth, and consequently the more women feel that they are not in control, the more likely it is that women will view childbirth as a dissatisfying and even distressing experience. It is noted that there has been an increasing trend towards medical intervention in childbirth since the early 1970's and that this affects, to some degree, almost all women giving birth (Welburn, 1980).

However, it is not just the event of childbirth that has been identified as unsatisfying or distressing for many women. Some writers have argued that all the experiences surrounding pregnancy, childbirth and motherhood are stressful and have the *potential* to cause dissatisfaction or distress. The literature examining post-natal depression has noted that the post-natal experience in hospital and at home, the behaviour of the baby, and feelings of satisfaction with motherhood are all important factors contributing to women's emotional well-being in the early weeks of motherhood (Oakley, 1980; Welburn, 1980; Ball, 1987). It is argued that certain social factors, such as social support, may offer women protection from depression during the early weeks of motherhood but nevertheless that these experiences are

potentially very stressful. Indeed, Oakley argues that the experiences brought about by pregnancy and childbirth make it a 'multiple stressful life event' (Oakley, 1980:182).

As well as the literature focussing on post-natal depression, there is a considerable amount of literature that identifies motherhood as an intrinsically stressful, frustrating and socially isolating experience for many women (Boulton, 1983; Gordon, 1990). This is likely to be particularly so in the early weeks of motherhood and for first-time mothers. While not all mothers experience dissatisfaction with motherhood, there is some evidence that, for many women, motherhood does not live up to their expectations. The demands made upon them by their babies and young children and the isolation that they may experience is often a far cry from the stereotype of motherhood portrayed in the media and this, it is noted, may cause feelings of disillusionment and dissatisfaction for many women. As Boulton notes, half of the women in her study

> 'found child care a predominantly frustrating and irritating experience. ... These women conveyed that they found pre-school children difficult and demanding to deal with over long periods of time; that they felt overburdened by their boundless obligations towards their children; that they found their children disruptive of their otherwise enjoyable activities; and that they felt guilt and anxiety as a consequence of the conflict between their responsibilities as mothers and housewives. They also complained of the lack of the interesting and stimulating company of those not involved in childcare and of the fact that their children tied them to their homes and the domestic sphere'
> (Boulton, 1983:204).

Thus the social-psychological, feminist and sociological literature on pregnancy, childbirth and motherhood reveals that, for many women, these experiences are fraught with anxiety and, for some women,

dissatisfaction. For some women, the event of childbirth is traumatic and the incidence of post-natal depression high. In addition, the frustrations of being tied to the house and a new baby are not at all what some women envisage motherhood to be like. Unlike some of the psychology literature, there is no mention in this literature that the dissatisfactions associated with pregnancy, childbirth and motherhood might lead to women eating or overeating. However, such action is a possibility given the literature discussed above which notes how food can act as a source of comfort, particularly for women, during times of stress. This might be particularly so during this stage in a woman's life cycle given that she would be likely to spend a lot of time in the home with open and easy access to food. It is important to examine whether some fat women experience ambivalent feelings regarding pregnancy and childbirth and whether this is linked to particular eating patterns that encourage even greater weight gains. Furthermore, what happens to fat women in terms of weight and eating after they have had their babies is also an important area of study, as is the effect such changes in eating behaviour and weight has on women's feelings about their weight.

Literature from social policy and from the sociology of food and eating has also identified changes in eating behaviour that may occur during, and as a result of, pregnancy and which may affect bodysize. Social policy studies have focussed on working-class families and have examined factors relating to income that affect pregnancy diets. It is argued that pregnancy demands the consumption of a better quality diet than that needed at other times but that many working-class women consume an inadequate diet becuse of a lack of money and the gender

specific behaviour of giving the 'best' food to the male partner and children (Doyle et al, 1982; Hanes, 1986; Cannon, 1987). Cole-Hamilton and Lang argue:

> 'A woman's diet is particularly important when she is pregnant ... As well as having increased need for dietary energy, her need for higher intakes of certain vitamins and minerals is even greater ... There is evidence that the dietary needs of pregnant women cannot be met financially by women on low incomes ... Some mothers from lower socio-economic groups suffer serious nutritional defects in pregnancy'
> (Cole-Hamilton and Lang, 1986:34).

Other social and economic constraints are identified in the sociological literature as determining diet in pregnancy. It is noted, for example, that pregnant women in paid employment and/or with existing family and domestic commitments may have little time or energy for shopping and cooking for what is seen nutritionally as the 'right' sorts of foods. In addition, what is available in shops and the types of mass produced and highly processed foods advertising encourages consumers to buy are often those that encourage weight gain (Olsen and Frische, 1987). Again, working-class women may be most vulnerable here with least time and energy available to cook and shop for food and, in general, less knowledge about nutrition than middle-class women. It is possible that such eating behaviours may affect weight gain, with high weight gains resulting from consuming high calorie foods and low weight gains (or weight loss) resulting from an inadequate diet.

Literature from the sociology of food and eating has focussed on two main areas in relation to diet in pregnancy: first, the extent to which cultural and social norms about food and eating in pregnancy encourage particular eating practices and behaviour; secondly, the way

the physiological and social changes brought about by pregnancy alter eating patterns and behaviour.

In the sociology of food and eating literature it is noted that there are general cultural and social beliefs about food and eating and that there are also ones that are specific to pregnancy (Stewart et al, 1988). Thus, many cultural groups and sub-groups have particular beliefs about the sorts and amounts of food that should be consumed during pregnancy. These food beliefs and practices may be very different to the recommendations for diet made by the various medical professionals that pregnant women come into contact with. However, in many instances cultural beliefs about food and eating are so strong that they are seen as superior to medical advice. There is some evidence to demonstrate the existance of these social and cultural beliefs about food and eating and the extent to which these are often in conflict with medical advice. Homans (1983), for example, carried out a study of Asian and white British women's perceptions of food during pregnancy. She found that Asian women have a strong tradition of dietary prescription during pregnancy and often did not follow the advice given to them by the medical professionals they came into contact with. British women, on the other hand, did not follow a particular diet during pregnancy but Homans did find that working-class women tended to follow lay advice about eating in pregnancy and that this was often in conflict with medical advice. She concluded from this that a woman's social class and ethnic background are important determinants of food beliefs and eating practices during pregnancy.

On the topic of medical advice regarding diet during pregnancy, Murcott noted that the way that such advice was given appeared to be a

factor militating against its being followed (Murcott, 1982b). She noted that dietary advice contained in booklets given out at ante-natal clinics concentrates on the nutritional value of food. However, she argues, women tend not to conceptualise food in this way; rather they think of food in terms of its domestic organisation and as a focus of family life. She argues, therefore, that medical advice about diet in pregnancy tends not to be followed by pregnant women because it ignores the social aspects of food and eating. Thus, it seems that cultural and social beliefs are very important in shaping eating practices during pregnancy.

The second area identified in the sociology of food and eating literature concerns the way the physiological and social changes brought about by pregnancy affect eating behaviour. In terms of the physiological effects of pregnancy, it is well-known that many women experience food cravings or aversions during pregnancy. Indeed these are acknowledged widely in the medical literature, where it is noted that the majority of women experience such symptoms (Hook, 1980). However, it is only in the sociology literature that these experiences and their effect on food consumption are examined in any depth. Macintyre (1981), for example, has noted that the physiological effects of pregnancy that give rise to nausea and other food-related symptoms lead women to crave or avoid certain foods. She notes that individual women experience and cope with these symptoms in a variety of different ways. Some women find that they need to eat considerably more, both in quantity and frequency, to keep these symptoms at bay. Indeed, Macintyre (1981) found that some women complained of always being hungry and of eating 'compulsively' during their pregnancy. Others, however,

find that they want to eat considerably less as a result of these physiological changes and Macintyre found evidence of this type of behaviour too. Murcott (1988) has also examined cravings and aversions in pregnancy and their effect on diet. In her study, she noted that the foods that were craved and avoided by pregnant women were those that are traditionally viewed as 'good' and 'bad' foods respectively. She argues from this that the effect pregnancy has on diet is often to encourage women to eat more healthily than they otherwise would. She observes: 'There is, then, fairly strong suggestion that these main features of cravings and aversions accord pretty closely with general lay nutritional conceptions of 'good' and 'bad' eating ... In the face of whatever disorder of eating pregnancy may entail, an image of order and ordinariness resurfaces' (Murcott, 1988:753).

The social changes brought about by pregnancy are also likely to affect eating patterns. Upon leaving employment, many women's eating patterns are disrupted and Macintyre (1981) found that often women ate more at home than they had done at work because they were bored. She also noted that because pregnancy is culturally viewed as a time when women should be 'spoilt', particularly in terms of food consumption, it often provided an 'excuse' for consuming certain foods sometimes in large quantities. The symbolic significance of changing eating habits as a way of confirming and signifying pregnancy is also seen as important (Murcott, 1988). Thus some women may welcome or seek such changes in appetite as a way of demonstrating that they are pregnant, just as some women may avoid them for the opposite reason.

The literature from social policy and sociology illustrates how women's social situation during pregnancy, cultural views about eating

during this period, and women's physiological experience of pregnancy may affect eating behaviour and, consequently, weight. Again, none of this literature relates specifically to fatness in pregnancy. However, it does demonstrate that social factors are important in determining diet. The impact of these on fat women's eating behaviour and feelings about their weight during pregnancy are important areas of study. Furthermore, charting whether changes in eating behaviour and feelings about weight survive pregnancy and the impact of the early weeks of motherhood on such behaviour are also of interest.

## 1.4 CONCLUSION

This concludes the review of the literature from various disciplines relating to fatness, eating behaviour and pregnancy. This literature has identified that fatness is often a particularly negative experience for women and is viewed both by the medical profession and wider society as an undesirable state. In addition, it is noted that women may be particularly vulnerable to eating behaviours that encourage fatness and that these may be difficult to change because of the ideology that surrounds family eating practices. As regards the period of pregnancy, there is some indication in the literature that this might be a period when fatness is more readily accepted by society in general. In addition, it is noted that eating practices can be subject to considerable changes during this period.

The discussions in the literature oulined above shed some light on the central question of this thesis: what impact does pregnancy have on fat women's feelings and experiences regarding their weight and their eating? However, as I have noted above, there is no academic study that

has focussed specifically on this issue. Five areas emerge as important topics for such a study. First, fat women's feelings and experiences regarding their weight before, during and after pregnancy and the factors which contribute to such experiences. Secondly, fat women's eating patterns and behaviour before, during and after pregnancy and the factors which contribute to these. Thirdly, the social organisation of food preparation and consumption and the impact that pregnancy and childbirth has on these. In addition, the extent to which the social organisation of food preparation and consumption can account for women becoming fat in the first place and make long term weight loss difficult. Fourthly, the medical and lay advice regarding weight and eating received by fat women during and after pregnancy and the effects of these on weight and eating practices. Finally, the experience of pregnancy, childbirth and motherhood and their impact on fat women's feelings about their weight and their eating behaviour.

An examination of these topics would provide information on the question of what impact pregnancy has on fat women's feelings and experiences regarding their weight and their eating. These topics form the basis of this thesis in an attempt to address this question. In the following chapter, I will discuss the methodology employed to examine these issues.

# CHAPTER TWO: METHODOLOGY

## 2.1 METHODOLOGICAL BACKGROUND

This research, as noted in the previous chapter, is concerned with examining the impact of pregnancy on fat women's feelings and experiences regarding their weight and eating. There are several different ways that data could be collected for this study: sociology does not have one single accepted paradigm of research methodology. While the subject of study, to a certain extent, dictates the type of research methodology used, this choice is dependent on the researcher's epistemological position which is in turn shaped by her or his views and experiences of the world (Hughes, 1976; Bulmer, 1977).

My epistemological position gravitates towards the idealist/ qualitative end of the methodology continuum. In my view, research should recognise that our experiences of the social world propel us to certain areas of study and our interests and experiences in these areas should be written into research design. Furthermore, I would argue that the most effective way of discovering information about people's lives is through qualitative methods of data collection. The particular experience and involvement in my life that has encouraged my interest in the area that I am studying is feminism. I will now go on to discuss whether the epistemological position of idealism is congruent with feminism and, furthermore, whether there is such a thing as a distinctive feminist methodology that could be adopted in this research.

There has been a wide ranging critique from feminists since the 1970's on the male dominance and bias in sociology (Stacey, 1981; Eichler, 1988; Smith, 1988; Warren, 1988). It is argued that sociology both in subject matter and method is male-dominated and sexist because

it has focussed on the concerns and interests of men and has excluded women from its analyses, either by ignoring them completely or by not recognising the significance of gender. There has been much discussion regarding the extent to which it is possible to have a research methodology that is feminist, and the form that this would take. These discussions centre round two major themes. First, there are the practical considerations. These focus on the principles of feminism as a political position and the way that these can be translated into a methodological practice. Secondly, there are the academic and theoretical considerations. These focus on how useful particular research methodologies are in analysing women's position in society.

The first set of considerations, which I have called the practical considerations, address the principles of feminism and how these can be related to methodological practice. All feminists hold the view that women are an oppressed group in society who have particular interests and experiences in common. The aim of the feminist movement, as with all political movements of oppressed groups, is to seek action and change on the fronts where oppression occurs. Identification of women *as a group* is seen as crucial to this and feminism has been at the forefront of breaking down divisions between women and highlighting the universality of oppression that affects all women. For feminists working within sociology the starting point of research would be to examine an area that would highlight women's oppression with the aim of linking this research to political action and change. The practice of such a piece of research, in accordance with feminist principles, would have to be carried out in ways that identified women with each other rather than in ways that created divisions between women. Thus, central

to research methods for feminists would be the need to employ a methodology that was non-hierarchical and non-exploitative and created a bond of common interest between the researcher and researched (Roberts, 1981; Stanley and Wise, 1983). As Oakley notes, 'One requirement for a feminist sociology is, then, that the postulate of value-free research has to be replaced by that of conscious partiality, which is to be achieved through an identification with the so-called .'objects' of research' (Oakley, 1986b:209).

There have been a considerable number of sociological studies carried out by feminists on women which have employed a particular methodology that has adhered to these general feminist principles. These start from an overtly politically-feminist standpoint and acknowledge their interest and involvement in highlighting women's oppression rather than hiding behind a cloak of neutrality. They recognise the importance of personal experience in both informing research design and achieving valid and reliable data. It is held that their shared structural position enables women carrying out research on women to formulate meaningful research. Furthermore, this enables the flow of valid and reliable information. Roberts, for example, notes the practice of this experiential approach: 'Feminists ... stress the need for a reflexive sociology in which the sociologist takes her own experiences seriously and incorporates them into her work' (Roberts, 1981:16). Finch argues that this approach leads to the acquisition of valid data:

> 'It seems to me that there are grounds for expecting that where a woman researcher is interviewing other women, this is a situation with special characteristics conducive to the easy flow of information ... However effective a male interviewer might be at getting female interviewees to talk, there is still necessarily an

> additional dimension when the interviewer is also a woman, because both parties share a subordinate structural position by virtue of their gender' (Finch, 1984:74,76).

The methods of data collection used in these types of feminist research have been some sort of unstructured or semi-structured interview. There is a great deal of discussion in the feminist literature regarding this. It is argued that the traditional style of interviewing recommended by sociology textbooks is inappropriate and unreliable and constitutes 'the masculine paradigm of interviewing' (Oakley, 1981:31). Oakley notes that this paradigm of interviewing is problematic for feminists involved in research on women for a number of reasons. First, it is unethical. Secondly, it is impossible to carry out in practice and thirdly, in reality the most effective way of obtaining valid and reliable data from an interviewee is to break down barriers and talk to interviewees on a personal level.

Within any research undertaking there are ethical dilemmas that need consideration. Within feminist research such ethical considerations are given a high profile because of the political dimension of feminism that demands an equal and non-exploitative relationship between all women. These issues are discussed in much of the feminist literature. The research methods favoured by feminist research are determined by certain ethical principles. This, of course, is true of most research: ethical issues must always determine the way research is carried out to some degree and there are invariably some trade-offs to be made between getting valid and reliable data and not exploiting the people being researched. In recent years there has been increasing interest and concern focussed on the importance of ethics

within sociological research design (Dingwall, 1980; Bulmer, 1982; Punch, 1986). However, the situation remains that an individual sociologist's ethical stance is broadly a matter of personal judgement. For feminist sociologists, it is their political stance as feminists that informs their particular ethical viewpoint. There are several principles that a feminist carrying out research on women would want to adhere to. These constitute ethical principles concerning the twin key ethical issues of informed consent and confidentiality. These are, first, that the reasons for carrying out the research and the methods to be used should be discussed fully with participants. Secondly, that the relationship between the researcher and the participants should be non-exploitative, non-hierarchical and reciprocal and thirdly, that the research findings should be made accessible to the people who have participated in the research (see Roberts, 1981; Stanley and Wise, 1983).

The question remains as to whether the type of research discussed above, which adheres to feminist principles, constitutes a distinct feminist methodology. There are two sides to this question. First, can research be called feminist only if it follows this particular model, and secondly, is this model distinctively different from other research methodologies? There has been much debate about the first of these points, whether only one particular form of research, namely qualitative interviews, can be viewed as feminist. Some feminists have argued that it is not the method but how it is applied and what is done with the data generated that determines whether research is feminist or not. It is argued that feminist research must start with the premise of women's oppression and be committed to researching an area that highlights this

with a view to improving women's position. However, the way this is done is not necessarily to follow one particular type of methodology (Graham, 1983). These arguments lead to the conclusion that there is not only one type of research methodology that can be called feminist.

The second point, whether the feminist methodology discussed above is distinctively different from other types of research methodology has also been hotly debated. Many writers have argued that so-called feminist methodology is not really any different from any type of good qualitative research. It is argued that all research should follow the ethical principles espoused by feminist sociologists and that the methods employed by feminist researchers in interviews are those that any good researcher would employ. These arguments are summed up by Deem who notes:

> 'There is little persuasive evidence or argument so far adduced in the debate about feminist methods which convinces me that feminist methodology is about choosing one method rather than another, nor has any one method emerged as distinctively feminist. ... what is crucial is whether the research sees an understanding of women's experience and a commitment to changing women's subordinate position in society as major priorities' (Deem, 1986:16).

I would agree with Deem's analysis that there is not one type of research methodology that feminists should adhere to. Furthermore, I feel that the type of research methodology, that of qualitative interviewing in a non-exploitative, non-hierarchical manner that is viewed by many as a feminist method, is not distinctively different to some other research methodologies.

I noted above that critiques of sociological methodology have focussed not only on the practice of how to do a feminist methodology, but also on its efficacy at uncovering accurate information about

women's lives (Graham, 1983; Smith, 1988). Such criticisms are obviously important. It is not adequate to put forward a research method that fulfills principles of feminism if it is ineffective at getting at the sort of information necessary to analyse women's position in society. There are, of course, many barriers to acquiring valid and reliable data through interviews. The type of feminist methodology that I have described does, in my view, go some way to removing many of these barriers. However, it would be naive to assert that they remove all these barriers. There are two points at issue here: first, the extent to which interviewees might respond to such methods by entering into conversations with interviewers, and secondly, the extent to which such conversations might lead to the discovery of 'the truth' about their lives.

To start with the first point, the extent to which interviewees might enter into conversations within the interview situation with interviewers employing a qualitative method, I would contend that such conversations are not likely to be as forthcoming as much of the feminist literature would have us assume. Finch, for example, argues that: 'If you are a woman sociologist, reasonably skilled in the arts of qualitative research and semi-structured interviewing, it is the easiest thing in the world to get women to talk to you' (Finch, 1984:70). I would agree that a woman interviewer, using a non-hierarchical, feminist approach, is more likely to get a woman interviewee to talk than a male interviewer or when another approach is used. However, it is not necessarily 'the easiest thing in the world to get women to talk' even when these methods are used. Some women are likely to talk very openly and to respond to these methods but others may not do so. I feel this

is largely a factor of personality and where shy, introverted women are being interviewed, even the most skilled woman interviewer is unlikely to get them to enter into a full conversation. I feel the feminist argument, when put in these terms, is something of an oversimplification. This is not to say that I think the feminist method of interviewing is inappropriate. However, I do feel some reservations should be acknowledged and that feminist methods should not be presented as the ideal type of methodology to overcome all interviewing difficulties.

The second point, the extent to which, when conversations are entered into, the information given is valid and reliable also needs discussion. Much of the feminist literature argues that gender is the most important factor in the acquisition of valid and reliable data (Finch, 1984). Other writers have argued that other differences, particularly those of class are equally important. Cornwell (1984), for example, notes that people can give 'public' or 'private' accounts of the same situation depending on to whom they are talking. The public account is the one that is viewed as socially acceptable and the private account is the one that reflects personal feelings. If the interview situation is an equal one where the inteviewee does not feel in some way inferior, then a private account is likely to be more forthcoming. There are, however, many bars to promoting feelings of equality in the interview situation. As Cornwell notes, while the interviewer and interviewee may be 'equal' in terms of their gender experiences, they may be 'unequal' in terms of class, race or education and these differences can lead the interviewee to feeling a need to relate a public or acceptable account to the interviewer. I feel that these

arguments are important ones that are often ignored in the feminist literature, thus presenting, again, an oversimplification of the research situation.

Thus, the type of methodology that has become known as 'feminist' is open to some criticism. It is obviously true that the method is not perfect. Indeed, in some contexts it may be inadequate in uncovering accurate information about women's lives. The two criticisms discussed above are ones that need consideration and, of course, there may be more that could arise from individual research undertakings. However, I would argue that these problems are not unique to this type of methodology. All research methodologies need to be judged with reference to their validity and reliability. Each has its drawbacks and advantages in theory but the only way these can be judged realistically is by examining how they work in practice in a particular piece of research.

In this section I have critically examined the notion of a feminist methodology and concluded that there is no such thing as one single feminist method. Furthermore, what has become known as feminist methodology, that is a particular type of qualitative interviewing, does not constitute a methodology unique and distinct from all others. Thus, while a particular approach has been used by feminists and is congruent with the feminist principles that I hold, it is not a necessary element of feminist research that it follows this particular model. However, in terms of this research, this is the type of research method that I chose to use. While it may not be the only 'feminist' method, it is congruent with feminist principles. Furthermore, it fits in with my

epistemological position and it is a method, therefore, that I felt would be most efficient in obtaining the required data.

I will now go on to discuss the methodology used in this research in detail, relating it to the preceding discussion of feminist research methods and ethics. I have called the method that I have used 'feminist' and mean by this the type of qualitative research that has been used by many feminist sociologists as discussed above.

## 2.2 THE RESEARCH PLAN

Feminist methodology holds that our experiences of life encourage researchers to pursue particular areas of study and that these experiences should be written into research design. I chose the research topic of fat women's feelings and expriences regarding their weight before, during and after pregnancy because of my own interests and experiences: of being a woman, of having experienced pregnancy, of having concerns with food and weight, and having an interest in the effects that the social and cultural expectations of society have on women. All of these interests and experiences have been informed by my interest and involvement in feminism and this in turn informed the research project. I have not experienced directly what it is like to be fat and pregnant. However, I did experience concerns with my weight after I had my children and have tried various diets at different points in my life in much the same way as some of my interviewees had. In addition, I joined a weight control group (WeightWatchers) during the early part of my research and this gave me a good understanding of the difficulties involved in attempting serious long-term weight loss.

Thus, my experiences and interests led me to choose a particular area of study and I tried to build on these as much as possible and to write them into the research design.

Given the subject matter and my feminist stance I felt the most appropriate method of gathering data would be to interview a sample of fat pregnant women. The method of interviewing that I aimed to employ was intended to be, as I have discussed above, what has become known as a feminist style of interviewing. That is, I intended that the inteviews would be non-hierarchical, non-exploitative and that they would be carried out in a conversational form with myself making contributions as well as the interviewee. I took the view of Oakley that: 'in most cases, the goal of finding out about people through interviewing is best achieved when the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own personal identity in the relationship' (Oakley, 1981:41). In adopting this approach, I felt it was important to make decisions regarding the style of interviewing and some of the ethical considerations before going on to think about question design for the interviews. The areas that I wanted to consider at this stage were the means by which I could develop a non-exploitative and non-hierarchical relationship when carrying out my research. I do not wish to imply that these considerations are unique to the feminist enterprise, as clearly they are not. Indeed, they should be central concerns of any research undertaking. However, I would like to demonstrate that my consideration of them and the decisions I made about them were very much dependent on my feminist stance.

In terms of non-exploitation, I felt it was important to be as open and honest as possible about the content and purposes of the research. After some deliberation, I decided against telling the women that the research was focussed on fat women because of my concern that this labelling could be harmful to their self image (this will be discussed in more detail below). However, I did intend to explain before the interview commenced exactly what sorts of things I would be asking them and to ensure that they consented to this. In taking this stance, I attempted to assess what the possible risks and benefits would be to interviewees of knowingly taking part in a study concerned with 'overweight' women. In terms of the benefits, I was aware that many studies have been identified as having a therapeutic effect on participants and I felt that this might be one of the benefits of participating in this study (see Brannen, 1988). Given that to be fat in a society that holds slimness as a cultural ideal is viewed as deviant, then discussions about the experience of being fat are likely to be quite beneficial. The risk involved in this, however, is that being singled out and identified as fat may result in making a woman feel worse about her weight than she did before. There is no easy answer to the question of whether the potential risks outweigh the potential benefits of participation. However, I decided in the end to err on the side of caution in an attempt to protect interviewee's self image and not to disclose the exact nature of the research.

I felt that this was the right decision because while it minimised the risks to the interviewee of taking part, it would not minimise the benefits. The interviewees would be told that the study was about weight and eating and they would therefore be able to talk about their

feelings about their weight as much as they wanted to but they would not be identified at the outset as fat. Thus, I felt the benefits of taking part in the research would be available to the women who felt able to take them, but it would not be a necessary part of participation to identify oneself as fat. I hoped to minimise the risks associated with talking about one's weight in the interviews by being sympathetic, relating my own experiences, assuring the women that they were not alone in their experiences and by giving practical advice regarding women's self-help or support groups where appropriate. I also planned to give assurances of confidentiality and to attempt to demonstrate that I would not be exploiting the women in this way.

Of equal importance to these issues of non-exploitation was the need to develop a non-hierarchical relationship. This I hoped to achieve, not only by telling interviewees as much about the research as possible, but also by telling them things about myself as a person. Thus, I intended to tell interviewees that I had two children and therefore knew what being pregnant and having children was like. In addition, in conversations about food, eating and weight, I intended to tell interviewees about my experiences where appropriate. Thus, I hoped to be able to make the interview situation a conversation between two women who had similar experiences rather than a formal question and answer session.

With these various principles in mind I set about constructing a questionnaire for the interviews. Because pregnancy is a process, or what Oakley (1980:187) has called a 'status passage', I felt it would be necessary to interview women twice. I thus anticipated interviewing the women once during pregnancy and once after childbirth to discover any

changes that might take place during these periods. I wanted to use the feminist model of interviewing that I have discussed above and this had to be borne in mind when constructing the questionnaire schedules for the interviews. Following this feminist model, I wanted the questionnaire schedule to be only loosely structured to allow conversation and discussion to flow naturally. I felt a more rigidly structured set of questions which had to be answered in a particular order would inhibit conversational flow and furthermore, would militate against the type of relationship, discussed in the feminist literature, that I wanted to have with interviewees. However, I did want to have some structure to my questions and not just topic areas to be covered within the interview as some feminist and ethnographic studies have. The reasons for this were that I felt my lack of experience as an interviewer might lead to areas being left out in interviews and, furthermore, that there might be difficulties involved in analysis of the material.

In constructing question areas for the questionnaire schedules I was influenced by the sociological studies of pregnancy and childbirth that have been carried out within a feminist perspective (Oakley, 1980; Macintyre, 1981) and also by feminist writings on size and eating disorders (Orbach, 1978; Chernin, 1983; Lawrence, 1987). My question wording was influenced by the many feminist studies that have been carried out (see Eichler, 1988). I tried to formulate questions that would allow interviewees to tell me stories about their experiences. Thus, most questions started with the phrase 'Can you tell me what happened when ..?' or 'can you tell me how you felt when ..?' This method has been used in feminist research and is seen as conducive to

gaining information on whole areas of women's experience rather than fragmented parts and is also one of the least exploitative methods because the interviewee rather than the interviewer tends to set the agenda of the conversation (Graham, 1984b). If such stories were not forthcoming, however, I had a series of probes for each question that would allow the area to be covered in full for each interviewee. In addition, I tried to structure the questionnaire in such a way that the order in which it was completed was unimportant. Thus, I intended to follow the general flow of conversation in asking the questions rather than the lay-out of the questionnaire itself.

It was intended that the first interview would take place sometime between the 30th and 40th week of pregnancy. At this interview information would be sought regarding the interviewee's experiences and feelings about her weight and eating before and during pregnancy, her experience of pregnancy in general, and the domestic organisation at home. It was intended that the second interview would take place about six weeks after the birth of the baby. At this interview information would be sought on the interviewee's experiences and feelings about weight and eating since the birth of the baby, her experience of childbirth and being a mother, the domestic division of labour, and any changes that had taken place in any of these areas since the first interview. I intended to write down the general responses given to me by interviewees but also to use a tape-recorder so that I would not need to concentrate too much on the writing to the detriment of listening and responding to the interviewee's conversation. The two interview schedules can be seen in Appendix 1.

In addition to the areas covered in the questionnaire schedules, I also felt it was necessary to gather some information from the interviewees about their background and their experiences throughout their lives up to the point of their pregnancies. All people are shaped by their past experiences and I felt it would be inappropriate to ask interviewees about their present attitudes without having some knowledge of what had gone before to shape these attitudes. I felt that this was particularly important because of the subject area which I was studying, that of weight and eating. Women's attitudes to their weight and eating immediately before and during pregnancy are likely to be shaped by their earlier experiences in these areas. I felt it was necessary to gather information about stressful life events as some writers note that these may be linked to fatness (Orbach, 1978; Lawrence, 1987). In addition, the gathering of background information such as parental occupation and interviewees' educational attainment and occupation were necessary for classification purposes.

I felt it would be inappropriate to use the questionnaire schedules to discover this kind of background information about the interviewees because it would involve asking a series of set questions in a fairly rigid format which would be likely to result in a brief question and answer type of format being established. This would be far removed from the feminist perspective that I wanted to use. Furthermore, it would establish a hierarchical relationship between myself as the interviewer and the respondent as interviewee with myself asking questions and recording answers without contributing anything. Thus I felt there was something to be gained from using a different type of method for eliciting this information.

I felt that the use of a form of the life history method would be appropriate to gather the data I sought in a useful and interesting way. The life history method has gained in popularity and use in recent years and is generally used to study in great depth one, or a few people's, life history and experiences (Faraday and Plummer, 1979; Plummer, 1983). The advantages of this type of method are seen as being that it gets at the process of a person's life and at the whole person rather than just an aspect of their being or experience (Faraday and Plummer, 1979). The way I intended to use the method was, of necessity, somewhat different to its general usage. I intended to use it to get at factual and experiential information about the interviewees' lives, in particular where these related to food and eating, and also to discover any traumatic or stressful life experiences that had occurred. However, this method was not intended to be the sole one employed or to be focussing on the most important part of the research and therefore would not be used as thoroughly or take up as much time in the interview as it might when used in other forms of research. I felt, however, that the way I employed this method still bought about the advantages of such a method, namely, that of valuing subjective experience and looking at life as a process whereby experiences contribute to forming attitudes and behaviour.

To use the method to get at the information sought I constructed a life history chart. This chart was divided horizontally into the years of an interviewee's life and vertically into sections covering age, housing, household members, education, occupation, food and eating, and, finally, weight and dieting. The aim was to get the interviewees to talk about their life history in general and in relation to food, eating

and weight and I would note this down within the structure of the chart. I intended to start the interviewee talking by asking her when she was born, where she lived and her parents' occupations and then to ask her to tell me what changes or movements had occurred as her life had progressed. I hoped in this way to discover classificatory information and any stressful life events that might have occurred. In addition to this I intended to ask interviewees about their early experiences and memories about food, eating and weight and their changing views and experiences in these areas. I intended to fill in the life history chart at the first interview before asking the interviewee the questions contained in the schedule discussed above. I intended to fill in this chart *with* rather than *for* the interviewee, thus allowing her to tell me about her life rather than me asking her a number of set questions about it. I did not intend to tape-record this part of the interview. A copy of the life history chart can be seen in Appendix 2.

Potential participants were to be contacted by a letter which would invite them to participate in the study. Because of the sensitive nature of the research, this letter proved very difficult to construct. I intended to carry out my research from within a femininst perspective and central to this is the need to have a non-exploitative relationship between interviewer and interviewee. Such a relationship demands that those potentially in the weaker position (the interviewees) should be informed fully regarding what the research is about, why it is being undertaken, to what uses it will be put and what participation will entail. In short, interviewees should have the opportunity of giving proper informed consent. However, where the research involves such a

sensitive topic as weight, giving all the information in a completely honest way may not be so desirable or indeed practicable.

To be completely honest and open about my research would have meant that in my letter to potential interviewees I would have to state that I was doing a study of women who were fat or overweight in pregnancy. I felt that there would be two main problems that would make such an approach impractical and, to some extent, unethical. First, in terms of the practicalities of getting a sample, such an honest approach would be likely to mean that the only people who responded would be likely to be those who acknowledged and accepted that they were fat and who had probably tried to do something about it. This is probably quite a small proportion of all women who would be defined as fat in pregnancy. Secondly, in ethical terms, I felt writing such a letter would be problematic. For women who did not feel that they were fat or who found their size hard to cope with, to receive such a letter identifying them as fat might actually be quite harmful to their self-image and may be perceived as insulting. I decided in the end to opt for a little less honest approach in the initial letter which I felt safeguarded the feelings of the women I contacted and furthermore, might mean a higher response rate. I did not feel this compromised my ethical or methodological position. Women were still informed about what the research was about, but in ways that were tactful; the letter wording explained the research as being 'a study of women's experiences of weight and eating before, during and after pregnancy'. A copy of this letter can be seen in Appendix 3. In making the decision to write the letter in this way, I followed the advice of Brannen who argues:

> 'Sensitive researchers tread warily ... and don't reveal all their hand at the outset. It is important not to

> prejudge the research problem by labelling it or defining its boundaries too closely ... This is especially important when the research topic is seen as problematic, either socially or psychologically, and is likely to prove stigmatising to those who admit to having such difficulties'
> (Brannen, 1988:553).

In order to identify women to participate in my research I planned to use the maternity records held at a large city hospital. I had been given informal consent by the hospital consultants for this. Researchers are often given open access to patients' records once Ethical Committee approval has been granted. Such a practice raises a number of ethical issues regarding the absence of patients' informed consent. However, it was not possible to gain access to a sample in any other way. The records hold patients' personal details, unobtainable from another source, which include details of weight and height. I anticipated from this that I would be able to identify women to take part in my research. Upon identification, I intended to send women the letter inviting them to take part, enclosed with which would be a post-card enabling women to indicate whether they would be willing to take part or not. Upon receipt of this post-card I intended to contact the women who were willing to participate to arrange the first interview.

Before this, however, it was necessary for me to identify a meaningful definition of 'fat' for my study. I wanted to interview women who viewed themselves as fat, and who were viewed as such by members of the medical profession. I therefore needed a definition that fitted in with personal views of fatness as well as medical ones. Determining this definition of fatness was difficult for obvious reasons. If I used a definition that was not viewed as constituting fatness in medical terms then the women that I interviewed would receive

no treatment or advice by medical professionals and thus I would lose one important topic of the research - that of advice given by medical professionals to fat pregnant women. However, the other possibility, that of using a definition that was not viewed as constituting fatness by the women I interviewed, had even worse consequences because I would be likely to be in a very embarrassing situation of asking someone questions that they didn't feel were relevant to them and might even be viewed as insulting. In such an instance an interview could be quite harmful to an interviewee's self-image and might set her thinking she had weight problems that she was previously oblivious to. Such a situation would have serious ethical consequences. Furthermore, in terms of the research it would be unlikely that I would get useful data from such interviewees.

In order to identify a meaningful definition of 'fat' for my study I turned to the medical literature on obesity in pregnancy. There are several definitions used in the medical literature as I have discussed in the preceding chapter. I decided that the most appropriate definition for use in this study would be the 90kg. definition. This definition classifies women, of any height, as fat if they attain the weight of 90 kg. during their pregnancy (Gross et al, 1980; Kliegman and Gross, 1985). The weight of 90 kg. is used because it is viewed as a 'critical' weight when attained in pregnancy and one that is associated with a significant number of medical problems. I felt that this method, because it uses a high level of fatness as a definition, would be an appropriate one to use in my study and would be likely to be a good inidicator of medical and personal views of fatness. In terms of the personal definition, I felt it was likely that women of average height

attaining this weight in pregnancy would be likely to view themselves as fat or overweight to some degree. I did feel it would be necessary, however, to check that the women I selected for interview were not exceptionally tall, as this would obviously affect their weight. In terms of the medical definition of fatness I presumed that this definition would suffice as it is one that is used widely in the literature. In addition, this method had the added advantage of being easy to use because no lengthy calculations of pre-pregnancy weights would be necessary.

Before I could actually start on the research I had to have my research proposal passed by the Ethical Committee. Although this process took some time and necessitated the propsal being re-presented on two occasions, the end result was that the research proposal passed by the committee was not very different to that originally submitted. The chief addition was that I should consult patients' G.P.'s and ask their permission first before contacting patients and asking them to participate in the study. Thus I constructed a letter to be sent to G.P.'s. This can be seen in Appendix 4.

Once I had agreement from the Ethical Committee I was in a position to start on the empirical part of the research. My intention was to interview about 40 women on two separate occassions. I intended to identify these women to interview from the records at the hospital of those attaining the weight of 90kg. or more by the 30th week of pregnancy. Upon identifying such women, I intended to contact their G.P.'s asking permission to invite their patients to participate in the research. Upon receipt of this I then intended to write to the women asking them if they would be willing to be interviewed.

## 2.3 THE RESEARCH IN PRACTICE

### 2.3(i) Getting A Sample

In practice, the research did not progress in quite the way that I had envisaged. The major problem centred around the process of identifying potential interviewees. I had envisaged that it would be possible to look through the records of all the pregnant women receiving ante-natal care at the city hospital at that particular time and from these to identify fat pregnant women. However, the record system in operation at the hospital meant that this was not possible. Instead it was necessary for me to go along to the hospital ante-natal clinics and go through the records that were got out for each clinic in order to identify potential interviewees. At each clinic there were generally about 25 patients and by going through the records of the women attending the clinics I was able to identify, on average, two patients per session eligible for the research. I was able to attend three ante-natal clinics per week. The process of identifying potential interviewees was, therefore, much slower than originally envisaged. In addition, because of the system of shared care that exists between hospital and G.P., I was not generally able to identify fat pregnant women from the records at the ante-natal clinics until they were about 30-34 weeks pregnant. This meant that time available to set up interviews was very short. It was necessary for me to write to G.P.'s for permission, to write to the women and to await a response before I could arrange an interview and I had, at the very most, 10 weeks in which to do this.

For these reasons, I decided to use additional channels to find potential interviewees. This I was able to do by getting access to the maternity records held at a cottage hospital in a suburban area where I was able to look through the entire records of pregnant women and to identify fat pregnant women in the way that I had envisaged doing at the city hospital. Obviously, the numbers of pregnant women were smaller there and consequently the numbers of fat pregnant women were too, but these did help to supplement those identified through the city hospital. In addition to this method, I was also able to gain assistance from the two G.P. group practices who worked from a health centre in another suburban area. They gave permission for their patients to be used in my research and the practice midwives agreed to co-operate in passing on names and addresses of pregnant women who fulfilled the 90 kg. criteria. These women too were passed on to me at an earlier stage than I could identify them at the city hospital and this was helpful in terms of time available to set up interviews.

The numbers of women who fulfilled the 90 kg. criterion was surprisingly high. In the twelve months spent on gathering a sample I identified 108 women as potential interviewees using the various methods discussed above. Unfortunately, however, the positive response rate of these potential interviewees was quite low, as I had anticipated. The reasons for this were complex, but I felt that the sensitive nature of the research and in many cases because the women were not contacted until quite late in their pregnancies might have accounted for a significant number of refusals. I have set out below the response rate of the women contacted and the means by which this response was generated.

Table 1

Response Rate

| | |
|---|---|
| *39 | Positive response by returned postcard. |
| 3 | Positive response as a result of visit/'phone call. |
| 12 | Negative response by returned postcard. |
| 11 | Negative response as a result of visit/'phone call. |
| 6 | G.P.'s refused permission for patient to be contacted. |
| 37 | No response. |
| 108 | (Total contacted). |

* I was unable to actually interview 5 of these women as they were admitted into hospital before the arranged interview.

Thus, of the 108 women identified only 42 agreed to be interviewed. Thirty-nine of these women agreed to be interviewed by returning the postcard enclosed with the invitiation to participate and three of these women agreed to be interviewed as a result of a follow-up visit or 'phone call. This makes a response rate of 39%. Only 37 of the 42 women who agreed to be interviewed were actually interviewed. Of the remaining 66 women, I was refused permission to contact women by their G.P.'s in six cases. The rest of the women (n60) either refused to participate or did not respond to the invitation to participate.

The method by which women agreed to participate in the research was by returning the postcard that I enclosed with the letter introducing myself and the research. The obvious drawback with this method was that potential interviewees might not have got round to returning the postcard. Thus, not responding might not necessarily indicate a lack of willingness to participate but rather lack of motivation to return the

postcard. In fact, only twelve of the 60 women actually returned the postcard refusing to take part in the research. I felt it was important to find out more about the group who did not return the postcard and I tried initially, where this was practical, to telephone or visit the potential interviewees in this group to ask them personally if they would be willing to participate. In some cases this was not practical to do because the women lived too far away, were not on the telephone or there was not enough time available to contact them. However, I did manage to contact 14 women identified in the earlier part of the research. The results were not very encouraging: of the 14 women contacted, only three of these agreed to take part as a result of this contact. The remaining eleven who refused gave various reasons for not wishing to participate, such as, personal problems, lack of time or lack of space in which interviews could be carried out. However, in several instances, it was obvious that it was the actual topic of research that was the problem. It was not uncommon for women to give firm and abrupt refusals which left me in little doubt that they had no wish to discuss the topic of weight and eating. I made no attempt to try to persuade women to participate once they had refused. I took this stance for two reasons. First, I felt it would be unethical and an abuse of my position of relative power to try to persuade women to do something which they had already clearly expressed a desire not to do. Furthermore, because of the sensitive nature of the topic, I felt it might actually be harmful to the women involved to persuade them to talk about areas of their lives that they found difficult. Secondly, I felt that even if I could persuade women to participate, the type of data obtained from such interviews might not be very useful given their

reluctance to take part. The low positive response elicited from follow-up visits or phone calls, coupled with the ethical issues surrounding this, persuaded me that such an approach was not really profitable. As a result, I did not follow up potetial interviewees identified in the later stages of the research who did not return the postcard.

A high response rate is obviously a desirable component of any sociological study. Where the response rate is low there is always a danger that the data collected may be representative of only a section of the population under study and not of the entire population. Furthermore, where that population is limited, a low response rate may mean that the actual number of respondents is too low to allow statements to be made about it. In terms of my study this latter factor was not a problem. While the response rate was low this did not mean that I could not find enough women to interview for the study: I had intended to interview up to 40 women and in the event I interviewed a total of 37. This I viewed as an adequate number to allow me to study the intended areas in sufficient depth. Whether those who responded positively represented a sub-group of the population is more of a problem. It is, of course, impossible to say whether the women I interviewed were representative of fat pregnant women as a whole. However, it is my view that in this study there were no significant differences between those women who agreed to be interviewed and those women who did not. The method by which I identified interviewees, that of having access to medical records, enabled me to discover some classificatory data on the women I invited to participate in my research. A comparison of certain key variables from these data such as

age, number of children, past pregnancy experience and weight revealed few significant differences between the two groups.

Table two shows the comparisons between the women who participated in the research (n37 - excluding those who agreed to participate but who were admitted into hospital before the first interview) and the women who did not participate (n66 - including those whose G.P.'s refused permission for them to participate). While participants were slightly younger (25.9 years compared to 26.4 years) and slightly lighter in weight (100kg. compared to 101.4kg.) than the non-participants, these differences were not marked. There were some differences between participants and non-participants in terms of previous experiences of childbirth. The most marked differences occurred between participants and non-participants who had previous experiences of pregnancy that had resulted in miscarriage, stillbirth, neo-natal death or adoption. A greater percentage of women expecting what was in effect their first baby (because of a previous negative outcome of pregnancy) agreed to participate than those with similar experiences who refused. However, the numbers here were very small and it is not, therefore, possible to draw any conclusions from this. A wider difference was in the percentages of participants and non-participants expecting a second or subsequent child who had experienced a previous negative outcome of pregnancy. In these cases, the percentage of non-participants was greater than participants. Possible reasons for this difference may be that women with such experiences might be reluctant to discuss them with a stranger and, furthermore, might feel anxious about the outcome of their present pregnancy which would be likely to militate against a willingness to participate in a research project discussing their

pregnancy. In addition, women with one or more child[ren] have less time on their hands and thus might feel that they could not spare the time to participate.

Table 2

Comparison Of Participants And Non-Participants

| | Participants | Non Participants |
|---|---|---|
| Average age | 25.9 years | 26.4 years |
| Average weight at 30 weeks pregnant | 100.0kg. | 101.4kg. |
| % first pregnancies | 40% (n15) | 45% (n30) |
| % second pregnancies after previous mis-carriage, stillbirth, neo-natal death or adoption of first child | 16% (n6) | 4% (n3) |
| % second or subsequent pregnancies | 40% (n15) | 23% (n15) |
| % third or subsequent pregnancies with previous experience of miscarriage, stillbirth, neo-natal death or adoption | 3% (n1) | 27% (n18) |
| Total | 37 | 66 |

The areas of differences in response rates, where they existed, was not perceived as being of particular importance in terms of the areas that I intended to concentrate on in the research. The major difference appeared to be in the group of women expecting a second or subsequent child where a previous pregnancy had had a negative outcome. This was not a specific focus of the study and the lower participation of women with such experiences was, therefore, not a problem in terms of the research. While it is not really possible to make conclusive comparisons between the two groups, especially when such small numbers are involved, I would contend that, on the basis of these variables at least, there were no significant differences between the two groups. Indeed, it appears that the greatest differences were in fact <u>within</u> rather than between groups. Both groups contained young women and older women, single women and married women, and women experiencing their first, second, third, fourth and even fifth pregnancies. Thus, I felt that the two groups were in fact comparable in terms of the diversity of experience contained in them and this led me to be optimistic that the sample I obtained was fairly representative of a population of fat pregnant women.

Before leaving this topic of response rates there is one further area that warrants a brief discussion. This area is, the extent to which the point of access from which I identified the potential interviewees had an effect on response. As I have discussed above, there were three main points of access: a city hospital, a cottage hospital and a health centre. At the city and cottage hospitals I went through the records and sent letters to women whom I wished to interview. The letter stated that the woman's name and address had been

passed on to me by the appropriate hospital where she was receiving her ante-natal care. In the case of the health centre, the midwives passed the letters on to the women that they came across during ante-natal clinics. The midwives then passed on the names and addresses of the women to me for follow up. The positive response rate achieved via these various points of access is set out below:

Table 3

Positive Response Rate By Point Of Access

| | Number contacted | Number participating |
|---|---|---|
| City Hospital | 74 | 17 |
| Cottage Hospital | 27 | 14 |
| Health Centre | 6 | 5 |
| Total | 107* | 36* |

* One additional interviewee was identified via a personal contact with a local G.P.

Thus, the largest number of women contacted were those identified from the city hospital. However, only 29% of those contacted agreed to participate in the research. Of those contacted via the cottage hospital, 52% agreed to participate and of the small number contacted via the health centre, 83% agreed to participate. Obviously the numbers of women identifiable from a city maternity hospital are going to be far greater than those a small cottage hospital and a town's health centres. What is of interest here is that women contacted via the smaller and more personal services offerred by the community midwives at the local health centres and the cottage hospital seemed more likely to respond

positively than those contacted via the inevitably more impersonal city hospital. Reasons for this are not difficult to find. There is much evidence to suggest that pregnant women feel alienated from the 'conveyor-belt' system of care that operates in most large hospital ante-natal clinics and that they are more satisfied with the more personal services provided by community based ante-natal clinics (Boyd and Sellars, 1982). It seems possible that those women who are approached by a local midwife or via a system of care that they are satisfied with may be more likely to agree to participate than those who are approached via a system that they are dissatisfied with.

2.3(ii) <u>The Interviewees</u>

The 37 women interviewed for this study were not a homogeneous group. They had two important characteristics in common: first, they were all pregnant and, secondly, they all weighed 90kg. or more by the 30th week of their pregnancy and therefore could be defined as fat. However, apart from these two factors, the women's backgrounds and experiences differed greatly. These differences in backgrounds and experiences were expected and indeed were viewed as an important part of the research given that, as has been noted above, the research was intended to be exploratory and to identify the importance of such groups of differences in contributing to women being fat in the first place and in shaping the experience of being fat before, during and after pregnancy. Some of the major differences between the women in the sample were in age, class, housing, marital status, number of children, and in their histories and past experiences of size, weight and eating. Differences in histories and experiences of size, weight and eating will be discussed in detail in the following chapters. Here I will

concentrate on differences in marital status, housing, social class, age and number of children.

In terms of marital status and housing, six women were living in their parents' home at the time of the first interview. Two of these women were co-habiting with their partners in the parental home. One woman lived alone. The rest of the women (n30) lived with partners in independent households. The housing tenure of the women was varied. Nearly half of the women lived in their own homes (n18, 49%), and just over a quarter lived in council accommodation (n10, 27%). Of the rest, six women (16%) lived with their parents, as noted above, and three women (8%) lived in private rented accommodation. The type of housing that the women occupied was related to social class, as would be expected, and this is demonstrated in tabular form below (see Table 5).

There is a great deal of controversy regarding the most appropriate methods of assigning social class status to individuals. Traditionally the Registrar General's classification of classes by occupation has been used but this method has been widely criticised in recent years (Marshall et al, 1989). As a result of these criticisms it has become conventional to use the classification devised by Goldthorpe which allocates people to a social class on the basis of their work and market situation (Abercrombie et al, 1988; Saunders, 1990). However, Goldthorpe's classification has come in for some criticism, particularly from feminist sociologists, because it views 'the family' as the point of analysis and the occupation of the male 'head of household' as the determinant of a family's social position. The contributions and experiences of women are, therefore, ignored (Abbott and Sapsford, 1987).

Given that my research was focussed entirely on women and that it was informed methodologically by a feminist perspective, it seemed inappropriate to use a social class classification, such as Goldthorpe's, that ignores women. However, I felt it would be equally inappropriate in terms of *this* research to use a classification that ignores men. The reasons for this were that my research focussed on women at a particular stage of their life cycle when, first, the majority lived in family units with male partners (n32, 86%) and secondly, when just over one third (n13, 35%) had not been in paid employment in the year leading up to the first interview. Thus, to focus entirely on women's occupations as a measure of social class would be likely to be both difficult and inaccurate in some cases.

As a result, I felt that the most appropriate classification for me to use would be one that took both partners' occupations into account where this was possible (that is, when interviewees had been working during the earlier stages of their pregnancy prior to the first inteview) but which otherwise allocated social class on the basis of partner's occupation. Such a classification would, I felt, be less sexist and give a more accurate indication of social class by taking into account women's employment than one that used male occupation only. The classification devised by Britten and Heath (see Table 4) fulfilled this criterion and is the one I have used in this study. In devising this classification, Britten and Heath noted that because of the ambiguous situation of female routine non-manual workers, women office workers should be classified as middle-class, but sales and service personnel should be classified as working-class (see, Abbott and Sapsford, 1987). In allocating the women in this study to a social

class category, I have followed this and defined those women who were occupied in clerical positions as being in RG class III and those in sales and service occupations as being in manual occupations. Those in Britten and Heath's classes I and II, I have termed middle-class and those in classes IV and V I have termed working-class. Class III is the cross-class group which cannot fit into either category.

Table 4

Britten And Heath's Social Class Classification

| | |
|---|---|
| Class I | Husband and wife both in Registrar General's class I or II or husband in that class and wife a full-time housewife, or one partner in that class and the other unemployed or absent. |
| Class II | Husband and wife both in RG class I, II or III (at least one in III), or husband in III and wife a full-time housewife, or one partner in III and the other unemployed or absent. |
| Class III | Cross-class marriages, not fitting any of these categories. |
| Class IV | Husband and wife in manual occupations, or husband in a manual occupation and wife a full-time housewife, or one partner in a manual occupation and the other unemployed or absent. |
| Class V | Husband and wife unemployed, or one partner unemployed and the other absent. |

(quoted in Abbott and Sapsford, 1987:20).

Using this classification, five women (13%) came into class I and eight women (22%) came into class II. This meant that a total of 13 women (35%) could be classified as middle-class. A total of 20 women (54%) came into class IV and one woman (3%) came into class V, thus making a total of 21 women (57%) classified as working class. Only three women (8%) were classified as being in cross-class families.

Allocating women to social class categories held some difficulties centring around the changing occupational status that accompanies pregnancy and the specific method I employed needs to be clarified here. The women were allocated to a social class using the above classification on the information given regarding their situation at the *first* interview, even though in some cases movement in or out of occupations following this first interview would have meant a change of social class classification. In addition, women were classified according to their own and their partner's occupation if they had been in paid employment during their pregnancy. Where women had not been in paid employment during their pregnancy they were classified as full-time housewives and were allocated to a social class according to their partner's occupation. Where women lived with parents only (without the presence of partners), they were classified according to their own occupation during their pregnancy as all these women had been in paid employment at this time. The following table shows the social class composition of the interviewees and their housing tenure at the time of the first interview:

Table 5

Social Class And Housing Tenure

| | Housing Tenure | | | | |
|---|---|---|---|---|---|
| | Own Home | Parental Home | Rented | Council | Total |
| Social Class | | | | | |
| I and II | 12 | 1 | - | - | 13 |
| Cross-class | 1 | 1 | - | 1 | 3 |
| IV and V | 5 | 4 | 3 | 9 | 21 |
| Total | 18 | 6 | 3 | 10 | 37 |

As Table 5 shows, the largest number of interviewees were working-class (57%) and these occupied properties across the range of housing tenure with the largest number being in council accommodation. In contrast, all but one of the middle-class interviewees, who made up 35% of the sample, were owner occupiers.

There were also quite wide differences in the ages of interviewees and in the number of children that they had. The majority of the women in the study had no children (49%) or one child (33%) at the time of the first interview. A smaller number had two (13%) or three (5%) children. Most of the women interviewed came in the middle age ranges: 38% were aged between 21-25 and 30% between the ages of 26-30. A further 13% were in the youngest age group of between 16-20 and a further 19% were in the older age group of between 31-35. Table 6 shows the ages and number of children of the women interviewed:

Table 6

Age And Number Of Children

| | Number Of Children | | | | |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | Total |
| Age | | | | | |
| 16-20 years | 4 | 1 | 0 | 0 | 5 (13%) |
| 21-25 years | 7 | 6 | 1 | 0 | 14 (38%) |
| 26-30 years | 5 | 2 | 3 | 1 | 11 (30%) |
| 31-35 years | 2 | 3 | 1 | 1 | 7 (19%) |
| Total | 18 | 12 | 5 | 2 | 37 |

Many of these differences between the interviewees will be discussed in the following chapters where relevant. In addition a brief outline of the individual women's backgrounds and experiences is contained in Appendix 5.

2.3(iii) The First Set Of Interviews

I planned to interview the women first sometime between the 30th and 40th week of pregnancy. In practice the women were generally interviewed at around 35 weeks of pregnancy. This was for two reasons: first, because at this late stage in pregnancy circumstances regarding weight and eating patterns would be unlikely to change and I felt that the women would feel that their pregnancies were coming to an end and would therefore be able to reflect back on their pregnancy experience more satisfactorily; and, secondly, because in many cases it was not possible to arrange interviews until late pregnancy because of the difficulties in contacting the women or because of their lack of time due to employment. Interviewing during late pregnancy did have some

drawbacks as it meant that there was a very limited time available in which to carry out the interviews. Not all pregnant women go the full 40 weeks before going into labour and indeed some fat pregnant women are admitted into hospital before term because of complications associated with their size. Thus, by leaving the interviews until late pregnancy there was a danger of losing some potential interviewees. This problem led to my losing five interviewees, in each case because they were admitted into hospital early either for rest due to medical complications or because they went into premature labour.

The interviews all took place in the women's homes. Thus, once I received agreement from women to participate in the study I contacted them, usually by telephone, to arrange an interview in their home at a mutually convenient time. I already had details from the women's hospital records of the estimated date of delivery of their baby and thus calculated from this an interview date when they would be approximately 35 weeks pregnant. There was no difficulty in arranging interviews with the women I contacted. All the interviews were arranged to take place during the day and, because it was difficult to predict how much time each interview would take, I limited myself to one interview a day. The interviewees' homes covered a wide and varied area of urban and suburban housing.

I felt that the initial impressions that interviewees had of me was important because of my desire to achieve a non-hierarchical relationship with them. I felt that both appearance and manner were important in developing this relationship. In terms of appearance, most of the women I interviewed were working-class or lower middle-class and because they were being interviewed in their own homes at a time when

they might feel physically unattractive I felt it was important to dress casually. An apparently middle-class researcher complete with suit and briefcase would, I felt, establish an immediate distinction between herself and the interviewee and this would not be helpful in terms of easy conversational flow. In terms of manner, too, I felt it was important to signify the similarities between myself and the interviewee.

Thus, on arriving at the interviewee's house I tried to be friendly and informal and to make some comments concerning the area, the house, the children, or the pregnancy. In this way I attempted to show that I had some experiences in common with the interviewee and also to try to create a friendly atmosphere that would be conducive to the flow of information in the interview. I was invariably offered tea or coffee upon arrival and I took this opportunity to sit and chat in general and also to give some information about the research before starting the interview. I told all the women that I was based at Southampton University and that I was doing a study of weight and eating in pregnancy, the aim of which was to discover how women felt about their weight and eating before, during and after pregnancy and the changes that occurred during these periods. I also told them that I had two children myself so knew what being pregnant was like, that I was nothing to do with their G.P. or the hospital and that anything they told me was strictly confidential. This explanation seemed to be satisfactory and seldom were more questions asked about the research before the interview although often following the interview a discussion about the research was initiated by the interviewees.

After the initial chat and explanation about the research I started on the interview. I asked the interviewees first if they minded my tape recording the interview as I would be unable to write down everything they said, and no one made any objections to this. The interviews started with taking the women's life history and details about their earlier experiences of weight and eating. This part of the interview was not tape recorded. After this, the interview concentrated on the questions contained in the interview schedule (see Appendix 1). I tried to approach these questions in a conversational manner, discussing areas as they arose naturally in the conversation rather than following the questionnaire format in a rigid fashion. Tape recording was essential for this part of the interview.

I found that I was able to achieve, in general, the type of interviewing style that I had intended. Obviously this was more successful in some cases than others, but in the main the women that I interviewed seemed to respond positively to the informal approach and were very open with the information they gave. I anticipated that there might be a problem in getting women to talk openly about some of the personal areas of their lives, particularly in relation to their feelings about their weight. However, in practice I found this was not a problem. Many of the women appeared to welcome the opportunity to talk about this topic. Some women were initially more reticent, but I was invariably able to draw them out on this subject by giving examples of feelings that other (anonymous) interviewees had expressed. Both the life history and the questions covered in the interview schedule led to the women talking about very personal, and in some cases traumatic, experiences in their lives. Such experiences as serious car accidents,

loss of a parent, loss of a child, eating problems and experiences of stigma due to being fat were all discussed quite openly. I felt that such information freely and openly given demonstrated that the method employed was appropriate for this study. The interviews lasted an average of one and a half hours, although some lasted considerably longer than this, and invariably took place in a relaxed and friendly atmosphere. Again, I felt that these factors attested to the appropriateness of the method.

In my discussion of feminist methodology, I noted that there are some problems with this method and that the way to assess the extent and significance of these is to relate them to the particular piece of research where the method is being applied. As I have noted above, I found the interviews were typically very successful and that women, in general, did enter into conversations with me. Thus, I felt that the problems identified in the preceding discussion are not particularly applicable to my piece of research. I felt that possible differences between myself and the interviewees that might have militated against the acquisition of valid and reliable data were few. I had similar experiences to the interviewees in terms of weight, eating and pregnancy and was therefore able to talk to them on their own terms. Furthermore, differences of class were not problematic. The majority of my interviewees were working-class and I too had a working-class background and became involved in higher education only very recently. In addition, as a single parent, I was well aware of the difficulties of living on a similar low income to many of my interviewees. Nevertheless, there were inevitably some interviews that were less

successful than others although the reasons for this were not, I felt, because of the particular methodology that was employed.

There were two sets of problems that I encountered: one relates to factors within the interview relationship between myself and the interviewees and the other relates to factors outside of this relationship where others impinge on it. The first set of problems that caused some interviews to be less successful than others occurred when I found I could not get interviewees to talk openly and at length with me about the topics under discussion. This happened in only one or two cases where I found that the strategies employed in other interviews that encouraged women to talk were unsuccessful and the women would only give short, one sentence answers. At the time I found these interviews quite worrying and felt that they reflected badly on my inteviewing skills. However in retrospect I felt, given that in the majority of interviews I was successful in getting interviewees to talk, that one or two unsuccessful ones are inevitable and probably more to do with the personality of the interviewee rather than a lack of expertise on my part.

The second set of problems, that of others impinging on the interview situation, had the potential to make interviews less successful than they might otherwise have been. When interviews are taking place in a person's home, there is always the possibility that other family members or, indeed, visitors to the home might be present. Such a presence may mean that the interviewee gives a less open or honest account than she would if she were on her own. Obviously, the best solution to this problem is to ask the interviewee if it is possible to interview her on her own. However, this is not always

possible either for reasons of space or because it is difficult for interviewers to make such a request. Additionally, even when it is possible to carry out an interview without someone else present in the room, the mere presence of others in the house may be enough to inhibit an interviewee's account for fear of being overheard. This is likely to be particularly so where there is a power relationship between the interviewee and the person present in the room or house, as in the case of a parent or male partner. Where this power relationship does not exist, with the interviewee's children for example, the problems are of a different nature but still have the potential to make the interview less successful than it might otherwise be. Here the problems are more ones of disruption and interruption that can militate against a good interview.

In the interviews that I carried out, the people who were present either at the interview or in the house were parents, partners and children. The first of these occurred in a few cases and the other two more frequently. Several of the interviewees were young, single, pregnant women still living in the parental home and there was therefore always the possibility that a parent would be present at the interview or at least in the house. In only one interview was a parent in the room during the interview. At this particular interview, the interviewee's sister and niece (a baby) were also present as they were visiting the house at the time. The house was small with no other sitting room and so I could not ask the interviewee if I could interview her in another room. Furthermore, I could not ask if I could rearrange the interview for another day as the interviewee's baby was due in a few days. Thus, I was obliged to proceed with the interview which was

probably less successful than it might have been because of the presence of others inhibiting the interviewee's responses. In two other cases, parents were present in the house, although not in the rooms where the interviews took place. In these two cases the presence of parents seemed to have little effect on the interview. In one, the interviewee appeared completely unconcerned and uninhibited about her parent's presence. In the other, although the interviewee appeared conscious of her mother's presence in the house, this did not appear to prevent her talking to me openly. Where topics were encountered that she didn't want her mother to know about, she either lowered her voice or prefaced her remarks with: 'Don't tell mum, but ... '.

The presence of partners occurred in seven cases. In two cases partners were present in the house but not in the room where the interviews took place. This did not appear to have any effect on the interview and the interviewees appeared completely unconcerned and uninhibited by their partner's presence in the house. In five cases partners were present in the room for part or all of the interview. This presented much more of a problem and had the potential to interfere with the interview to a marked degree. Again, it was not possible for practical reasons to ask partners to leave the room during the interviews. The impact of a partner's presence on the interviews was varied. Surprisingly, in three out of the five cases where partners were present the effect appeared to be positive. While partners tended to give their views about what they <u>thought</u> their spouses thought and felt about things, this seemed to lead to a better interview in these three cases. It led to these interviewees discussing and negotiating responses which I felt made responses more, rather than less, accurate.

This was primarily because the women were not adverse to disagreeing with their partners' views and so it was the women's views and not their partner's that came across. The following excerpt from one of the interviews illustrates this:

Partner: 'But your appetite has definitely increased since we've been married.'
Carol: 'Mm.'
Partner: 'Your actual portions that you actually eat ... It was never like that before.'
Me (to Carol): 'Why do you think that was then?'
Carol: 'I think it was him encouraging me to eat.'
Partner: 'I don't think it was me, you can't pin that one on me.'
Carol: 'It was. I just never thought about eating before, I never had time. I was too busy, working, getting ready and going out I never thought about eating. ... I wouldn't have dreamt of eating biscuits and cakes before. My mum never bought them and I never thought about eating them.'
Partner: 'No you're right, that was me. That was my fault. I'm a big sweet eater.'
(Carol Smith).

This conversation was fairly typical of the negotiations that occurred when interviewing three of the women when their partners were present. Most feminist researchers would argue for the need to interview women separately when carrying out research focussing on women's experiences and this is a position that I would agree with. However, I felt that in these three cases where this was not possible it was not thoroughly detrimental to the research and indeed may have been fairly positive. This is not to say that interviewing spouses together would have been a desirable option for all the interviews. The reason for the relative success of these three interviews was I felt because the women did not display a subservience to their partner's views and this was probably due largely to the fact that the couples were all middle-class. For other couples the same might not be true and

interviewing spouses together in such instances might not be so advantageous.

In the two other cases where partners were present throughout the interviews the results were much less successful and the subservience of these women to their partners may have accounted for this. These two couples were working-class and adherence to traditional roles for men and women may explain the difference between these couples and the ones discussed above. In these two instances it was not so much what *was* said in the interviews as what *was not* said. The men tended to be comparatively quiet while their spouses were being interviewed but their presence nevertheless appeared to inhibit the women from talking about particular subjects in detail, particularly where this might be seen by their partners as a criticism of them. The following excerpt from an interview illustrates this:

> Me: 'Can you tell me how you and your partner organise things that have to be done in the home like housework and cooking?'
> Fiona: 'I do most of it. He gets his fads when he does things but not very much.'
> Me: 'Are you happy with that?'
> Fiona: 'No.'
> Me: 'So you wish he'd do more?'
> Fiona: 'Yes. (looks at husband playing with child) It's a good job he's deaf isn't it?'
> (Fiona Tindall).

This quotation illustrates how the presence of partners can inhibit women from giving full responses to topics in the interview situation, particularly where those topics might involve a criticism of their partners. Fortunately this situation only occurred in two cases and even in these, the effect on the data overall was probably not too great. Fortunately, the topics which women displayed a reluctance to discuss, because they involved a possible criticism of their partners,

were few and even then the general gist of the situation could be gleaned from the responses, as with the above quotation.

There were 11 cases where interviews took place with young children present. The sorts of problems likely when interviewing women with their young children present are: that the interviewee's attention will be diverted by their child's needs or behaviour; that the interviewee will feel self-conscious about her child's behaviour and will not be able to give her full attention to the interview; and, that the child may seek attention from the interviewer and thus interrupt the interview. I encountered all these difficulties when interviewing women with their young children present. However, these are not necessarily insurmountable problems that inevitably lead to an interview being unsuccessful, they merely demand different skills in dealing with the interview situation. I tried to create a relaxed and informal atmosphere in the interviews and spent some time talking to the child on arrival at the house. I tried to convey from this that interruptions from the child were not a problem and, indeed, were to be expected. In 10 out of the 11 interviews carried out with young children present I felt this was successful and that the child's presence made no difference to the quality of data obtained. In these interviews the atmosphere was relaxed and friendly and this allowed the presence of children and the necessary interruptions that this entails to be handled in much the same way as they are handled in normal conversations. It has to be said, though, that the children in these 10 interviews were very co-operative in this. In the other interview that I undertook with a child present, the child was not so co-operative and demanded

attention constantly, much to his mother's embarrassment. This meant that the interview was less successful than it might have been.

2.3(iv) The Second Set Of Interviews

The second set of interviews were scheduled to take place about six weeks after childbirth. The period of six weeks was chosen because I felt it would be soon enough after the birth for the birth event to be recalled with clarity. However, I also felt it would be long enough after the birth for the interviewee to have settled into some sort of routine with the new baby so that my presence would not entail too much of an intrusion. Furthermore, I felt that any new eating patterns that fitted in with having a new baby would have been established and that weight would have stabilised to some extent. In practical terms too the six week point was the most appropriate. Some women may consider returning to work or seeking employment at this stage and it is the time of the final post-childbirth medical check-up, thus signifying a return to normality. However, I made no hard and fast rule that all interviews *had* to take place at the six week stage. Given the difficulties of arranging and fitting in interviews this would probably have been impossible anyway. However, I did try to arrange the second interviews so that they were carried out sometime around the six to nine week stage.

To arrange the second interviews, I contacted the women, usually by telephone, about five weeks after the estimated date of delivery of their baby that they had given me. In the majority of cases, childbirth had actually taken place at least a few days after the estimated date and so there was plenty of time to arrange the interview for the six week point. In all the cases the interviewees were happy to arrange a

second interview. Obviously the women had less time available to them to sit and talk given their new responsibilities, but none of the women voiced any concern about this. Again, all the second interviews were arranged to take place during the day and I limited myself to one a day as I had done with the first set of interviews.

In general, the second set of interviews were a lot easier to conduct than the first. I had already met the interviewees and established a relationship with them and so the problems of creating an impression that would lead to good interviews were not present. In general, it seemed to be that the second interviews followed the pattern established in the first. Where the first interview was very successful this was not a problem, but where the first interview was less successful it was sometimes difficult to break the pattern and turn the second interview into a more successful one. One reason for this was probably that the second interview relied, in part, on information given in the first interview. Where this information lacked depth it followed there was less on which to base a second interview. However, this was not always the case and in some instances second interviews went much better than first ones had. Where this occurred, one of the major reasons seemed to be when women had a particularly good or bad experience of childbirth that they wanted to talk about. In fact the focus on the event of childbirth made the task of carrying out and improving the second interviews somewhat easier as all the women were able and willing to talk at length about this event and about their new baby and its impact on their lives. This then, to some extent, made the task of talking about the more sensitive areas of weight and eating easier. As with the first set of interviews, I found that I was able to

carry out these interviews in a similar conversational manner. Indeed, because I had already established a pattern for this, and because the presence of a new baby gave rise to such conversations, this task was somewhat easier with this set of interviews.

The problems encountered in the first set of interviews were, as I have just indicated, followed through into the second set. The patterns established in first interviews of having adult members present in the room or house were mirrored in the second interviews. These were, in the main, not problematic, or at least not more so than they had been in the first set of interviews. I anticipated that the presence of a new baby might cause distractions for the interviewee or might mean that she would not want to spent too long on the interview. However, I found this was not the case. The needs of the new baby were such that they did not interfere with the interview and the interviewees all gave of their time generously so there was no need to cut interviews short. These second interviews lasted an average of one hour.

## 2.4 THE VIEWS OF MEDICAL PROFESSIONALS

As the interviews progressed it became apparent that there was a need to have some information on the views of medical professionals regarding various aspects of the research. The major reason for this was the surprising finding from the interviews that advice from medical professionals to fat women regarding weight and eating both during and after pregnancy was rare. This was unexpected because, as was noted in the previous chapter, there is a wide medical literature focussing on the health risks associated with being fat in pregnancy and the importance of advice to prevent excessive weight gains. I hypothesised

that there were a number of possible reasons why medical advice was not routinely given to the women in the study. First, it might be that the definition of 'fat' that I used, while it corresponded to medical definitions in the literature, did not correspond to medical definitions in practice and thus the women did not receive advice because they were not viewed as fat. Secondly, it might be that, in contrast to the medical literature on weight and pregnancy, medical professionals in practice did not view fatness in pregnancy as a particular health risk or viewed it as a health risk that they, rather than the woman concerned, should assess and deal with. In both these instances advice to the women concerned would not be given. Thirdly, it might be that medical professionals did give advice to women but that the women did not perceive it as such and therefore reported that they did not receive advice. In order to examine these issues, I constructed a questionnaire for medical professionals.

A variety of medical professionals come into contact with pregnant women. Most central of these are hospital consultants, hospital midwives, G.P.'s and community midwives. I felt it was important to get some information from all these sources regarding the above issues so as to get a clear picture from all the major medical professional groups that come into contact with women during pregnancy of views about weight and eating during pregnancy. The views of medical professionals were not intended to be a central part of this research and therefore I did not feel it was necessary to interview a large number from the medical professional groups. I did not intend to discover if each medical professional that a woman had come into contact with had given advice to her or not in order to verify her reporting of this event. Rather, I

intended to get some idea of the views of medical professionals in general regarding weight and eating during pregnancy. This was in order that I might verify both the definition of 'fat' that I used and the general findings regarding advice reported by the interviewees.

With these aims in mind I wrote letters to the following people asking if they would be prepared to be interviewed for this part of the study: one of the consultants and the midwifery sister at the city hospital; a group of community midwives attached to the suburban health centre; and five G.P.'s. Most of these people had been contacted before during the earlier stages of the research and those who had not, had at least some knowledge of the research that I was undertaking. The letters written to all these medical professionals were more of a re-introduction of myself and the research rather than a first introduction. This, I felt, might mean that a positive response to the interviews from the medical professionals would be more likely. The G.P.'s contacted were selected from those who had given permission for their patients to participate in the research. They were stratified according to area and sex and then selected randomly. Two G.P.'s from city areas and three from suburban areas were selected. Three of these were male and two female. The letters to the various medical professionals and the questionnaire can be seen in Appendix six.

The response to the request for an interview from the medical professionals was not as good as I had anticipated. I wrote twice to the consultant at the city hospital and asked if he could pass the letter on to one of his colleagues if he felt he could not see me but I had no response to either letter. The response from the G.P.'s too was

not as good as anticipated. Two G.P.'s responded positively to the original letter and were interviewed. One of these was male and the other female and both practised in city areas. I followed up the G.P.'s who did not respond with a letter and a slightly changed copy of the questionnaire that I had intended to use for the interview which I asked them to fill out and return to me. One of the male G.P.'s practising in a suburban area did this. Thus, I had a response from three out of five of the G.P.'s. The response from the midwives was much more positive. Both the hospital and community midwives responded quickly and positively to my letter and I interviewed the midwifery sister of the city hospital and a group of five community midwives from the suburban health centre.

While the reponse from the medical professionals was not as good as I had hoped for I felt it was adequate for the purpose that I had intended. The intention was to identify some of the general views of medical professionals regarding weight and eating and to verify my definition of fat. I felt that the views of the medical professional groups of G.P.'s and midwives regarding these topics were adequately represented as a result of the interviews. Unfortunately the same was not true for consultants from whom I had no input. There was nothing I could do about this as my requests for interviews were not responded to. However, the information obtained in the interviews of medical professionals that I did carry out revealed some consensus, at least on the topic of advice giving, which seemed to be in accordance with the experiences reported by the women interviewed. As a consequence, I saw no reason to think that this would be altered significantly if I had interviewed consultants too. The interviews carried out lasted on

average about thirty minutes. The interview with the group of midwives was tape-recorded but at the rest I wrote down responses. There were no major problems or difficulties with any of these interviews.

## 2.5 ANALYSIS OF THE DATA

There is an extensive literature that discusses the difficulties inherent in analysing qualitative data (see Burgess, 1984). The major difficulties centre around the fact that qualitative methods of research generally focus on participants' experiences and interpretation of the world and these are not amenable to the more rigorous methods of quantitative analysis. In practice this results in two chief problems: first, there is often no way of checking that an interviewee's responses are 'the truth' because these responses concern personal feelings which, by their nature, cannot be verified by reference to other people; and, secondly, to analyse qualitative material it is necessary to look for themes in the data and this necessarily involves some selection on the part of the researcher. Nevertheless, qualitative methods are widely used and respected within sociology and there is a substatial literature that discusses the validity and reliability of such methods (Wiseman, 1978; Burgess, 1984; Graham, 1984b; Warren, 1988).

The data obtained from the interviews with the women were analysed by dividing and summarising interviewees' responses from the transcribed interview tapes and life history questionnaires into topic areas relating to the periods of before, during and after pregnancy. From this it was then possible to identify the recurring responses within the topic areas. The common responses within the various topic areas were generally quantifiable and in the following chapters I have, where

practical, set out the numbers of women reporting a particular incident or experience and given examples from the data or case studies to illustrate these. The data obtained from the medical professionals were analysed in a similar way.

It was only possible to cross-check the interviewees' responses in relation to one aspect of the research, that of advice from medical professionals, where the views of medical professionals as well as the women were sought. In all the other aspects of the research the responses made by the women were accepted as valid. I did not view this as problematic or affecting the validity of the research; possible barriers to the achievement of valid and reliable information via semi-structured interviewing were eliminated as far as possible, as has been discussed above. Additionally, the degree to which similar responses occurred pointed to the validity of the data.

## 2.6 CONCLUSION

This, then, outlines the methodological background to the research. A group of 37 fat women were interviewed using semi-structured, qualitative interviewing techniques on two separate occasions. The first interview taking place between the 30th and 40th weeks of pregnancy and the second, around six weeks after childbirth. These women were defined as fat using the medical definition of a 90kg. weight obtained during pregnancy which was viewed as fulfilling medical and personal definitions of fatness. The women were interviewed on topics relating to their feelings and experiences regarding their weight and their eating. In addition, a small group of medical professionals were interviewed on their attitudes to fatness and diet during

pregnancy. The findings of these interviews are outlined in the following chapters.

## CHAPTER THREE: FEELINGS AND EXPERIENCES REGARDING WEIGHT AND EATING BEFORE PREGNANCY

### 3.1 INTRODUCTION

In this study I set out to examine the impact of pregnancy on women who are fat and the criterion selected to define 'fat' in this context was a weight of at least 90kg., regardless of height, attained before the 30th week of pregnancy. The range of weights around this 90kg. point attained by the 30th week of pregnancy by the women will be discussed in chapter four. Here, I want to concentrate on the women's weights before pregnancy and their experiences and feelings regarding this.

Details of the women's pre-pregnancy weights were obtained from their maternity records. On these records an early pregnancy weight is recorded from the woman's first ante-natal visit which usually takes place at around 16 weeks of pregnancy. While this is not strictly a pre-pregnancy weight, it is likely to be quite close to this (see Walker et al, 1976; Treharne, 1983). Thus, by noting this early recorded pregnancy weight I was able to get a fairly close approximation of the women's weights before pregnancy. In the cases where early pregnancy weights were not recorded, such as when women did not attend early ante-natal appointments, the women were asked what they weighed before pregnancy and this weight was taken as their pre-pregnancy weight.

The mean average pre-pregnancy weight of the women interviewed was 91kg.. However, there was quite a wide range of weights either side of this average. At the lower end of the range, three women (8%) weighed between 70-79kg. and, at the upper end of the range, eight women (22%) weighed 100kg. or more. The highest weight was 138kg.. Most women

centred around the middle range, with 13 women (35%) weighing between 80-89kg. and the other 13 women (35%) weighing between 90-99kg. As has already been discussed, I have not taken account of height in defining fatness or obesity for this study, although exceptionally tall women were excluded unless their body weight was such that it compensated for this. However, it is worth noting some details of the women's heights here. The average height of the women interviewed was 168cm.. Thirteen women (35%) were some way below this average with heights of between 157-165cm. and 7 women (19%) were some way above it with heights of 172cm. or more. The tallest woman in the sample was 181cm.. The largest group of women though (17 women, 46%) came in the middle range with heights of 166-171cm..

Table 7

TABLE OF INTERVIEWEES' WEIGHTS AND HEIGHTS BEFORE PREGNANCY

| | HEIGHT | | | |
|---|---|---|---|---|
| | 157-165cm. | 166-171cm. | 172cm.+ | TOTAL |
| WEIGHT | | | | |
| 70-79kg. | 1 | 1 | 1 | 3 |
| 80-89kg. | 4 | 9 | - | 13 |
| 90-99kg. | 3 | 5 | 5 | 13 |
| 100kg.+ | 5 | 2 | 1 | 8 |
| TOTAL | 13 | 17 | 7 | 37 |

Although there is a wide range of weights and heights within this sample of women, all the women can be defined, using medical criteria, as fat to some degree. While definitions of fatness vary, as discussed

above, most would consider these women as fat to some degree. For example, the calculation of the body mass index would define even the tallest and lightest of the women as fat (see Gilbert, 1989). The use of charts of average weights for women would have a similar result (see Blundell and McArthur, 1979). It seems likely too that a group of women of above-average weight would perceive themselves as overweight and it is the women's feelings and experiences relating to this that I will now go on to discuss.

## 3.2 FEELINGS AND EXPERIENCES REGARDING WEIGHT

The great majority of the interviewees reported a considerable amount of dissatisfaction with their weight before pregnancy. Thirty-one women (84%) reported some dissatisfaction with their weight and in many cases this dissatisfaction caused them extreme distress. Of the remaining women only three (8%) were unreservedly satisfied with their weight and a further three (8%) were satisfied as they had dieted and lost weight immediately before becoming pregnant. For the three women who were unreservedly satisfied, their weight was not an issue in their lives and not something that they devoted any time to thinking about or trying to change. In the case of two of these women their age and past experiences regarding their weight may have accounted for this. These two women were aged 33 and 27 respectively and had been fat since childhood. Their weight before pregnancy was in the higher weight group as they both weighed over 100kg.. It seems likely that these two women had learned to accept their weight as an unalterable fact of their life and had, over the years, found ways of coping with it so that it no

longer caused them distress. The following response sums up both women's attitudes regarding their weight:

> 'When I was overweight a few years ago I was a bit more self-conscious but I've got to the stage now where I accept it and I sort of think: well, if you can't take me as I am then that's too bad. I am as I am, as they say, and that's the way I'm going to stay'
> (Judith Osborne).

The other interviewee in this group who was satisfied with her weight was younger and did not have the childhood experiences of being fat that the other two women had. Furthermore, at 90kg. she weighed considerably less. However, this woman was the exception in feeling satisfied with her weight.

The further three women (8%) who reported satisfaction with their weight before pregnancy had, as I have noted above, all lost weight immediately before their pregnancies began. Two of them had been following a WeightWatchers diet and had been attending weekly classes and the other one was dieting alone by cutting down on her calorie intake. While they had not lost all the weight that they planned to, they had all lost a considerable amount of weight and, compared to how they felt about their weight before the diet, they felt much more satisfied. However, they all acknowledged that they still had some more weight to lose before they could feel completely satisfied. This response was typical of this group's answers to the question of whether they were satisfied with their weight before pregnancy:

> 'I was so chuffed, I was feeling great. My husband was, "Yeah, get yourself some new clothes". It was great. It's the fact that everyone says to you "Gosh, you look wonderful". I was probably still twice as big as what they were but it gives you so much'
> (Sandra Crocker).

The great majority of women though, as I have noted above, were dissatisfied to some degree with their weight before pregnancy. However, while the women were clear that they were dissatisfied with their weight, articulating why this was or what in particular bothered them about their weight proved difficult. The reason for this was, I think, quite clear. As has been discussed in chapter one, there is an immense social pressure on women to attain and retain slimness and it is women, rather than men, who are more likely to view themselves as fat, to attempt to lose weight and to be stigmatised for being fat (Gilbert, 1989). There is considerable evidence that many of the fat women in this study had a low self-image as a result of their size because they equated fatness with unattractiveness. This explains why most of the women interviewed gave short and negative answers to the question of whether they were satisfied with their weight and why they could not easily articulate why they felt this way. In our culture women want, and need, to be attractive and to be attractive a woman must be slim. This necessity is a fact of most women's lives: it is so obvious that the question is almost redundant. It is part of an unwritten agenda, a commonsense knowledge that exists between women, that all women want to be slim and all fat women, therefore, are dissatisfied with their weight. The fact that it can not easily be articulated why this dissatisfaction exists reinforces the point. It is seen as so obvious and natural that women want to be slim that, just as with other so-called 'natural' forms of divisions between men and women, there is no language with which to discuss it (see Spender, 1980). The following example was a typical response:

> Interviewer: 'Were you satisfied with your weight before you became pregnant?'

Respondent: 'I'm never satisfied with it.'
Interviewer: 'Can you tell me what you didn't like about it?'
Respondent: 'It's just the fact of being overweight that bothers me.'
(Louise Marsden).

Such a response can be seen as perfectly understandable in the light of the above discussion. To overcome the pervasive power of the cultural norm of slimness as a feminine ideal and to both accept and feel satisfied with being fat would undoubtedly take a great deal of courage, strength and support. That the three women discussed above appeared able to do this is indeed remarkable and it is unsurprising that they were very much in the minority in this sample of women.

A group of British women, however, have set about trying to change this almost universal view that to be a fat woman is unacceptable. This group, who model themselves on similar groups in America, call themselves 'The London Fat Women's Group' and they have received quite a lot of media attention and broadcast a television programme on BBC2 in February 1989. The group holds that fat women are oppressed because of their size but that rather than trying to change and become thin, fat women should accept and indeed celebrate their size. Thus, the group have attempted to set up an alternative ideology to that of mainstream and 'malestream' culture that views fatness as bad and to make women's struggle to accept their weight more easy (see Teddern, 1989). I asked the women I interviewed if they had heard of the 'Fat Women's Group', if they agreed with their philosophy and if they thought that, with the support of others who felt the same way, they could ever imagine coming to a point where they could accept their own weight. Most of the women had some knowledge of the 'Fat Women's Group' and its philosophy.

However, such is the strength of the dominant culture that none felt that she either could or would want to learn to accept, let alone be satisfied with, being fat:

> 'I've accepted the fact that I never will be slim but I would never stop trying. I would never give it all up, you know, say fat is beautiful and all that. I would never do that. I would always be conscious of it' (Katie Price).

Thus, the majority of women were dissatisfied with their weight and wanted, ideally, to be slimmer. It was dificult for the women to articulate just why they felt dissatisfied with their weight given that it is a taken-for-granted view held by most people that fat women would prefer to be slim. However, on further discussion, three main areas emerged as presenting difficulties for the women in terms of their weight and were seen as reasons why they would like to lose weight. These areas were: first, buying and wearing clothes and personal appearance; secondly, taking part in social and sporting activities; and thirdly, comments from family members and others and a desire to lose weight to please them. Surprisingly, no women made reference to health as an area of concern regarding their weight. Thus, even though there has been an increasing emphasis on fatness as an unhealthy state in recent years, these women did not consider this a primary concern. The following table shows the numbers of women in each weight category who attributed the above three areas as reasons for feeling dissatisfied with their weight. As can be seen from the table, for many of the women these factors operated together in contributing to their dissatisfaction with their weight. Thus, while for some women only one of the areas was

identified as the reason for their dissatisfaction with their weight, for others, two or three areas were identified.

Table 8

REASONS ATTRIBUTED TO DISSATISFACTION WITH SIZE

| | REASON | | |
|---|---|---|---|
| | Clothes and Personal Appearance | Sports and Social Activities | Comments |
| WEIGHT CATEGORY | | | |
| 70-79kg. (n2) | 1 | 1 | - |
| 80-89kg. (n12) | 8 | 6 | 4 |
| 90-99kg. (n11) | 8 | 6 | 4 |
| 100kg.+ (n6) | 3 | 3 | 5 |
| TOTAL (n31)* | 20 | 16 | 13 |

* Only those who reported dissatisfaction with their weight (n31) and not the whole sample (n37) are included in this table.

3.2(i) Clothes and Personal Appearance

Buying and wearing clothes and personal appearance was the most commonly cited reason for wanting to lose weight. This is perhaps unsurprising given society's focus on women's personal appearance and women's desire to project an attractive image. Out of the 31 women who were dissatisfied with their weight before pregnancy, 20 women cited clothes and personal appearance as a primary area of difficulty. One of the main reasons, relating to clothes, for feeling dissatisfied with their weight was that many women felt unable to wear the sorts of clothes that they would have liked to wear. It may have been that such

clothes were not available in their size. However, the most prohibitive factor was not availability, but personal sanctioning. The sorts of clothes these women felt that they would like to wear but felt unable to, were those that reveal expanses of body, such as bikinis, shorts and short skirts:

> 'I don't dress the way that I want to anymore because of my weight. Like, I won't wear shorts or anything like that, no matter how hot it is. Mark says "Oh, wear shorts" and I say "No"'
> (Fiona Tindall).

Another factor that made women feel bad about their weight was not being able to wear clothes that they had worn in the past, because they could no longer fit into them. This was a common problem. Many of the women noted that they kept clothes that used to fit them in the hope that one day they would be able to get back into them again. However, it was often felt that such a possibility was unlikely and that keeping such clothes merely served as a constant reminder and punishment for having gained weight.

The act of actually buying clothes was also cited as a major problem. This was not only because the women were selective and wanted to buy particular clothes that they thought were suited to fat women, but because clothes shops that carry 'larger' sizes are relatively few, although there has been a move more recently towards shops catering specifically for large women. Most of the women noted that there were no clothes shops in their immediate area that catered for their size and that to find clothes to fit they had to go to the larger city-centre chain stores - a round trip of 30 miles for some interviewees. It should be noted that many of the women who reported the lack of shopping

outlets for fat women were not excessively overweight. Many of these women were only slightly larger than average but argued that, nevertheless, they could not buy clothes to fit them because their local fashion shops carried nothing larger than a size 14. For young fat women this was noted to be a particular problem because they often wanted to dress in current fashion styles but shops that cater for this age group, even city centre chain store shops, rarely carry large sizes. Certainly, it would appear that the pressure from the fashion industry on young women to be slim is great indeed. The wearing of fashionable clothes is an important part of teenage culture, and to be excluded from this because of one's size is likely to be quite damaging. One young woman, herself able to buy clothes from a young fashion shop, gives a clear example with her choice of words of what not being able to do so would mean:

> 'I've never had to go to outsize shops or anything like that. I just go to 'Chelsea Girl' like *normal* people' (Josie Robbins).

For older fat women too, while they are subject to less pressure to wear highly fashionable garments, shopping for clothes is still viewed as a problematic experience. First, they often would like to buy clothes that are not obtainable in their sizes, so that, while they may not be highly fashion conscious, they would still like to wear more fashionable clothes than are available. Secondly, as I have noted above, they have to make a sometimes long journey into city centre chain store shops to buy clothes because local or smaller shops do not cater for them. Thirdly, clothes from such shops are generally more expensive than can be bought locally. However, even overcoming these obstacles

there are other factors that make shopping for clothes in itself an unpleasant experience for all fat women. The major problem seems to be that shopping for and buying clothes makes fat women have to face up to the fact of their fatness. This occurs in various ways: by having to go to the end of the rack where the large sizes are kept; through having to try things on in changing rooms and to view their image in the mirror; and, by the almost inevitable comparisons with other, thinner, women who are either shopping for clothes at the same time or working as shop assistants. Thus, shopping for clothes forces fat women to confront their size which at other times they may be able to find ways of avoiding. The following comments regarding shopping for clothes were common:

> 'I hate buying clothes because you see all the smaller sizes and half the shops don't cater for the bigger person in any case'
> (Julie Woodford).

> 'Even 'Evans' in town, it's all thin people who work there and they come up to you and say "Can I help you?" and the best thing to say is "No" because you've got to do it yourself and see how you look with all your lumps and bumps in things. I hate shopping for clothes. I think all fat people do'
> (Susan Hartwell).

Shopping for and buying clothes are, then, difficult experiences for fat women because they make them feel particularly conscious that their appearance is not as it should be, because they are fat. Given that for all women personal appearance is so important such feelings are likely to be a primary factor in shaping fat women's experiences and feelings regarding their weight. It is this feeling of not looking as they 'should' that structures their behaviour and determines their experiences of their social worlds. Thus, their feelings about their

personal appearance being not as it should be comes first. These feelings are internalised to such a degree that they determine fat women's behaviour and legitimate the behaviour of others towards them. This can be seen in examining the other two areas that women identified as problematic in terms of their weight: taking part in sporting and social activities, and comments from family members and others or wanting to lose weight to please them. The fact that these emerged as problematic is, I would argue, precisely because women have internalised the idea that they look 'wrong' to such a degree that they feel they no longer have a right to respect from others or to full participation in normal social life.

3.2(ii) Participation In Sports and Social Activities

In terms of participating in social and sporting activities, 16 of the 31 women who expressed feelings of dissatisfaction about their weight found difficulties in this area to such a degree that their participation was severely restricted or even non-existent. A further eight women felt very self conscious about their participation but felt able to participate, in many cases, by taking along their children or going with a partner. Sporting activities, and particularly swimming, were viewed as being almost 'out of bounds' for fat women. Many of the women claimed they would never go swimming, although the presence of children and the necessity to go 'for them' did lift this prohibition somewhat. The major difficulty reported with swimming was the necessity of wearing a swimming costume and therefore exposing flesh which is not a practice that fat women feel comfortable with. Other sporting activities which demand similar exposures of flesh, such as keep-fit or aerobics, were similarly viewed as difficult by the women. Sporting

activities which do not demand such exposure, however, were still avoided. In general, women at this stage in the life cycle, unlike men, do not tend to participate to any great extent in such sporting activities (Deem, 1986). Horse riding and games like badminton and squash, however, are sports that are favoured by women. These, though, were positively avoided by this group, even by fat women who had pursued such sports with keenness when slimmer. In most cases the reasons for not participating in such activities seemed to be a view that it was not something that fat people should do, coupled with feelings of self-consciousness or a fear that someone would draw attention to their weight:

> 'I loved horse riding and when I got really heavy I wouldn't have gone horse riding, you see... Because I was always frightened that I'd turn up at the riding stables and they'd say "No, I'm sorry, you're too heavy to get on a horse", you know. I knew they wouldn't but it's just the thought that, oh God, that would be so embarrassing'
> (Josie Robbins).

However, it was not only sporting activities that fat women felt excluded from because of their size. Many women reported feeling out of place participating in ordinairy social activities such as going to the pub for a drink. Indeed, some women reported that they found going out anywhere led to their feeling out of place and self-conscious:

> 'I don't like going out, to be honest, I really don't like going. Me and my husband rarely go out, you know. I wouldn't dream of going to a disco. But, you know, just going to the pub or anything I'm really conscious of it'
> (Angela Downer).

> 'Sometimes when I've been to pubs, I mean, there've been times when I've never taken my coat off, just sat there with my coat on because I've felt so awful. People say "Why don't you take your coat off?" and I say "No, no". They couldn't think what was wrong'
> (Brenda Gray).

The reporting of such feelings demonstrates the degree to which fat women feel they do not deserve a rightful place to fully participate in society. That a fat woman can say that she feels so bad about her weight that she doesn't like going out at all seems an extreme statement. But this is not an isolated comment. The majority of the women who reported feeling dissatisfied with their weight claimed that they felt self-conscious about participating in social activities to some degree. For some women this meant that the only way they could cope with this was to minimise outings altogether; others felt able to cope with continued participation even though this was painful. Thus, those who felt barely able to participate in social life at all are one end of the continuum where to feel bad about being fat is a normal response. Moreover, the women were only too aware of the cause of their problem and the solution:

> 'My confidence would go sky high if I was slimmer. I'd feel I could just, you know, walk into a place and feel good. I don't think there's anything I couldn't do if I was slimmer'
> (Brenda Gray).

3.2(iii) Comments

The third area identified by the women as difficult was that of comments made by partners, kin, friends and even strangers regarding their weight. Many of the women noted that they were, or had been, subject to comments from strangers regarding their weight. Obviously such comments serve to reinforce fat women's views of themselves as 'bad' and may lead to feelings of low self-esteem and a consequent reluctance to participate in social activities. The women felt very hurt and angry when such comments were made about them although some

women, particularly the older women who had been fat for many years, found ways of coping with them so that they did not get too upset about them. However, while women may have reacted angrily to comments, they did not show this anger and generally ignored comments. Partly this may be a response to disparaging comments (when made by men) that all women learn and reflects their subordinate position in a patriarchal society. In the particular case of fat women, I would argue, this serves to reinforce feelings of low self-worth and leads to self-blaming. Fat women are likely to feel if they weren't fat, they wouldn't receive such comments and therefore that it must be their own fault. Indeed, it is likely that many fat women feel that somehow such comments are to some extent justified because they believe that it is wrong to be fat.

Comments from partners, kin and friends regarding the women's weight were also fairly common. Thirteen of the 31 women who were dissatisfied with their weight received comments regularly and/or wanted to lose weight specifically to please their partners or children. Some comments from partners were particularly hurtful and undoubtedly led to feelings of low self-worth and self-esteem. For example:

> 'My husband calls me names like 'Jumbo' and things like that ... He drops hints and that and he says to people "Oh, I only married half of her". Well it was really, I was only half the size I am now'
> (Jackie Johnston).

Derogatory comments from men to their female partners regarding their weight were reported as a common occurrence in Charles and Kerr's study (1988) of women, food and eating. They noted that the majority of women reported dissatisfaction with their body size and that they often related this to their partner's comments and ideals regarding their weight. Thus, they argue that many women want to retain or obtain their

partner's view of the 'ideal' (i.e. slim) weight in order to ensure that their partner stayed with them. This is probably the effect that partners' comments had on the above group of women. Indeed, many reported that they wanted to slim 'for' their partners.

However, the majority of the women who reported feeling dissatisfied with their size noted that their partners would make comments to them about their weight only during an argument (n18) and that they either 'wouldn't dare' to make comments or were happy with their weight because they 'love me for what I am'. This is in contrast to Charles and Kerr's study (1988) which found comments from partners regarding weight the norm. The probable reason for this is that, unlike the women in Charles and Kerr's study, many of the women in this study had been overweight when their partners had met them and so they had not known them to be any different. However, whether partners made comments or not, all the women still ideally wanted to lose weight. For example:

> 'He's a smashing bloke. He'd only say something in absolute bad rows. But he knows I've got such a bad lack of confidence that he'd only ever try to encourage me to diet because he knows that's what I want. I'm sure at the back of his mind he'd really love me to be slim for himself and because we'd have a better relationship because I'd be happier. But he'd never say anything' (Sandra Crocker).

Thus, the above discussion demonstrates that fat women are likely to feel dissatisfied about their weight to some degree. I have argued that this dissatisfaction stems from their feelings about their attractiveness, which is viewed as being greatly diminished because of their size, and that such feelings arise because of the stress put on all women's physical appearance. These feelings are reinforced by the mass media, the diet and slimming industry, and partners, kin, friends

and even strangers who pass comment on fat women's size. So pervasive is the view that all women must be slim that fat women are likely to internalise this view to such an extent that they feel they no longer have a right to respect from others or to fully participate in the social world. Obviously, the extent to which this is so varies from woman to woman, but nevertheless there is a great deal of evidence from my research to show that fat women are likely to experience some feelings of low self-worth and self-esteem as a result of their size. While there were some exceptions to this in the sample interviewed in this research, it appears that feelings of dissatisfaction about their size is likely to be the norm for fat women.

## 3.3 STIGMATISATION OF FATNESS

There is a considerable amount of evidence to demonstrate that fatness is a stigmatised condition: that is, that people experiencing it are, to some degree, discriminated against, rejected, avoided and viewed as not 'normal'. Moreover, the stigma associated with fatnes is such that, unlike many other forms of stigma associated with physical conditions, people experiencing it are held to be personally responsible for their condition (Allon, 1975; DeJong, 1980; Worsley, 1981). The existing literature demonstrates that fat people are viewed as having stereotypically unpleasant characteristics and are discriminated against in almost every area of life including education, employment and health. In addition to direct discrimination, fat people are also likely to internalise the attitudes held by the majority of society.

It is impossible to say whether the fat women in my sample were victims of direct discrimination as information was not collected on this topic. However, the preceding discussion has demonstrated that many of the women internalised negative attitudes to fatness. This was so much the case that many of them came to a position of secondary deviation whereby they felt that their whole identity was strictly defined in terms of their fatness (see DeJong, 1980). Undoubtedly, this is detrimental to them but whether this caused them to be downwardly mobile is not clear. The majority of the sample (n21, 57%) were working-class but it does not necessarily follow that downward mobility as a result of fatness is an explanation for these women's class position. Rather, as much of the literature on fatness has noted, economic and cultural factors leading to the consumption of a particular type of diet may explain why working-class people, and particularly working-class women, are most likely to be fat. However, I would argue that discrimination and, probably more importantly, feelings of low self-worth leading to under-achievement and few ambitions may be a partial explanation for why working-class fat women move to, or remain in, the lowest social class positions. Obviously, the class position that women start from is important in leading them to be fat in the first place but, once fat, it seems likely that for working-class women, movement into higher class positions is hampered by their size. The use of two examples from the fat women I have interviewed may help to illustrate this:

*Example one*: Jenny Harris.

This young woman reported always being aware of being overweight and being 'constantly' nagged about it by her mother. She was first

referred to a hospital dietician for dietary advice when she was eight and has attended, on and off, ever since. She reported feeling self-conscious about her weight and recalled being teased about it at school. She disliked school a lot and often truanted and thus did not achieve educationally. She became pregnant when she was 15 and her boyfriend moved in to the parental home where she lived with her father. In terms of her decision to keep the baby and leave school she noted:

> 'If I'd have known that I was going to do well at school and that I'd have a really lovely career in front of me, then maybe I would've thought twice about having it [the baby]. But I hated school, I didn't pass any of my exams, well I passed them but I didn't get no grades to brag about. So, I knew, I knew I wasn't going to do well at school ... Mum says "when the baby's born you're going to get really fed-up, you're going to want to go out with your friends". But I don't think so. I think I'll be quite happy at home'.

*Example two*: Sally Harman.

This woman recalled being slim up to the age of six or seven and then putting on a lot of weight which gradually built up through the years. She tried many different diets to try to lose weight, some initiated by her G.P. and some by herself. She reported feeling very unhappy and self-conscious about her weight. She left school at 16 and got a job in a factory where she stayed for three years until she met her husband and got married when she was 19. She became pregnant shortly afterwards. She did not return to paid employment after her first pregnancy. Her husband is a merchant seaman and usually away at sea for three months and then home for one month. They live in a tower block and much of her time is spent at home and on her own. She noted that she does not go out much socially, just shopping and taking the children to school. Regarding motherhood versus employment and her lack of a social life she said:

> 'I've never had any ambitions or anything. I've always wanted to be a mother. I suppose if I was thinner, well I wouldn't be more active because I'm active enough now. I do tend to walk everywhere and everything and I don't like pubs so I don't suppose there'd be that much difference but it's hard to say. Sometimes fat people when they get thin they completely change their life.'

In both these examples the women did not attain well at school and consequently were in a position where the only employment open to them was low-skilled and low-paid. They both lacked ambition, and settled with partners and became mothers in their teens and appeared to have, and be satisfied with, little social contact outside of their roles as mothers. This is not an unusual path for young women to take and certainly not one that is confined only to fat women. Variables such as social class and gender are obviously crucial in determining the choices, or lack of them, that are open to young working-class women and there is a wide literature documenting these (see Taking Liberties Collective, 1989). However, I would contend that bodysize may put further constraints on women and that these may inter-relate with other variables in doing this. The constraints associated with bodysize may operate in much the same way as the constraints of social class and gender. Fat children may be discriminated against and where variables such as class and gender enter into the relationship this is likely to be accentuated

It is not possible to make definitive statements regarding underachievement of fat women on the basis of such a small and unrepresentative sample. Indeed, the occupational achievement of some of the women in the sample might be seen to contradict such a theory anyway: of the 28 women (76% of the sample) reporting that they had

'always', or since their early to mid-teens, been overweight, ten (36%) achieved five or more 'O' levels and/or went on to pursue a full-time vocational course. However, the women who achieved this all came from upper-working-class or middle-class backgrounds and thus, their employment attainment is not really surprising. In these cases their class background was probably sufficient to overcome the social handicap of fatness in terms of education and employment achievement. Nevertheless, it is possible that there is some association between fatness and underachievement amongst fat women. I would argue that fatness may put constraints on women, particularly when it exists alongside constraints of class. This may be demonstrated in this study by the fact that the majority of women in the study from working-class backgrounds left school to enter low skilled jobs, such as factory and shop work. While such employment patterns may be due to other factors, the possibility of fatness as an influencing factor can not be ruled out.

Also of interest is the finding that the majority of women in the sample both married (or cohabited) and had a first pregnancy at quite an early age. Taking the women identified above as being overweight 'always' or from their early teens (n28), of those who left school with few or no qualifications and entered low-skilled employment (n18), 14 women had their first pregnancy by the age of 21 and a further two women were married by this age. The average age of marriage or cohabitation for this group was 19 years and the average age for first pregnancy was 20 years. Even those women who secured more high status employment did not lag far behind in this. The average age of marriage or cohabitiation for the women in the higher status employment was 22 years

and the average age of first pregnancy was 25 years. While the age of marriage or cohabitation of this group of women may not be far below the mean, it may demonstrate that marriage and motherhood are viewed by fat women as being advantageous states in ways that they are not for women of average weight. Therefore, they are options that fat women may pursue more readily than most.

The 'escape route' for many working-class girls from a life of poor employment and low wages is seen as being marriage and motherhood. For girls who are fat, whether they be in poor employment or not, this 'escape route' appears to offer even more. It allows them to opt out of the competition for a man and the necessary physical attractiveness that accompanies this. Additionally, it is a state that brings about greater social status and social acceptability. Thus, for fat women, marriage may be a great boost to self-confidence. Motherhood too, perhaps even more so than marriage, may be an advantageous state for fat women. Having children presents an opportunity to legitimately leave paid employment and to spend a lot of time in the home which is likely to have some appeal to fat women who find participation in the social world problematic. In addition, the fat and cuddly stereotype of 'mother' stands in contrast to the slim and lissome stereotype of 'lover' and this is likely to have some appeal to fat women. There was some evidence from the interviews that marriage and motherhood, to some extent, led to greater feelings of social acceptability and legitimated bodysize. The following quotations illustrate the point:

> 'I feel more confident about my weight since I've been married because, I think, I've got my man. I know it's a stupid attitude to have but, um, you know, he loves me for what I am'
> (Katie Price).

> 'I felt different before I had David [her son]. I know at one time, before I had David, I can remember going out with friends and being very self-conscious .. but not since I've had David. ... I think when you've got a child you use them as a shield anyway. You know, you do things for your child so it doesn't matter what people think of you'
> (Amanda Spelling).

Of course, acquiring a partner is not necessarily the end of the story, as actually keeping hold of a partner may be the more difficult task, particularly in the current climate of high divorce rates. However, none of the women I interviewed expressed anxiety about this. Divorce or separation may be a common occurrence but this group of young married or cohabiting women felt that it was unlikely to happen to them.

Opting for marriage and motherhood, however, while it may appear to be a choice that can bring benefits for fat women, is not a choice without drawbacks. It has been well documented that these states are often oppressive for women and frequently lead to financial and emotional dependence on male partners and associated powerlessness (Oakley, 1980; Boulton, 1983; Delphy, 1984). However, many fat women may see such drawbacks as acceptable trade-offs for the attainment of social acceptability. This is not to say that marriage and motherhood are experienced as any less oppressive states by fat women than they are by women of average weight.

Thus, I have argued here that being fat is an experience that, for the majority of women, is extremely problematic. Because of the emphasis put on women's physical appearance, it may lead to their experiencing feelings of low self esteem and social unacceptability. As a consequence, they may underachieve educationally and occupationally

and may seek to minimise social contact. One way of doing this may be to opt for marriage and motherhood at the earliest possible age.

## 3.4 FACTORS LEADING TO FATNESS FOR WOMEN

Given that the experience of being fat causes so many problems for women, and that they perceive that the only real 'solution' to it is to lose weight and so become slim, it is important to examine how the women came to be fat, and why changing this is so difficult. In examining these issues I do not intend to give a strictly causal explanation, that is, to say women who are fat are so because of particular factors. Such positivist statements would not be possible to make on the basis of this research and indeed the research was not designed to give such answers. Rather, I intend to do two things here. First, to identify factors that the women *perceive* as important in causing them both to become fat in the first place, and to make losing weight in the long term difficult; and secondly, to identify factors that emerged from the data as important in these two areas. Thus, the explanations here will be used to make *associations* or to identify predisposing factors that may encourage women to become and remain fat. These factors will be identified from the women's perceptions and also from my own interpretation of the data.

In the review of literature in chapter one, I discussed a number of explanations that have been put forward to explain the 'cause' of fatness. Some writers emphasise physiological causes unrelated to eating, others emphasise psychological or social causes that are related to eating, and many see these factors as inter-related in explanations for fatness. Unsurprisingly, a variety of different factors emerged

from the research as possible explanations or predisposing factors leading women to become fat. The majority of these were concerned with eating in some way. However, many women also identified factors connected with their physiological functioning and, while these were not necessarily unrelated to eating, they had more of a physiological basis. The following table shows the factors identified by the women as causing their fatness. In this table the women have been divided into three groups: those who reported that they had 'always' been fat; those who reported that they had been fat since their teens; and, those who reported becoming fat after the age of 20. As can be seen from the table, many of the women attributed a variety of factors that operated together in causing their fatness. Thus, the explanations discussed below are not intended to be mutually exclusive.

Table 9

CAUSES IDENTIFIED FOR FATNESS

| | CAUSE | | | |
|---|---|---|---|---|
| | Physio-logical | Life Event | Food and Eating 1* | Food and Eating 2* |
| FATNESS PERIOD | | | | |
| 'Always' (n24) | 11 | 11 | 15 | 8 |
| From Teens (n9) | 2 | - | 4 | 3 |
| 20+ Years (n4) | - | 2 | 4 | 4 |
| TOTAL (n37) | 13 | 13 | 23 | 15 |

* Food and Eating 1 = the practical organisation of food and eating.

* Food and Eating 2 = the ideological organisation of food and eating.

3.4(i) Physiological Factors

Much of the clinical literature on fatness notes that metabolism may be a factor in predisposing certain people to be fat. Some literature from psychology and sociology also argues, in a similar vein, that many people are fat genetically and that there is nothing such people can do to achieve and maintain slimness other than to starve themselves (Wooley and Wooley, 1979; Schoenfielder and Wieser, 1983; Jenkins and Smith, 1987). Furthermore, it is argued in this literature that dieting may actually contribute to the problem by slowing the metabolic rate and thus resulting in a greater weight gain after a diet on a relatively small amount of food.

A total of 13 women (35%) felt that their fatness was, in part, genetic or that they had a slow metabolism which caused them to be fat. In many cases, the women viewed their fatness as being inherited and noted that many, or all, of the female members of their family were fat. However, while genetic factors such as these were used as a partial explanation for being fat, they were not used as a justification. Thus, while some women felt that there was some inevitability about their size because of hereditary factors, this did not lead them to accept their weight as 'normal'. While their weight could have been seen as 'normal' *for them*, in that it followed a familial genetic pattern, it was not viewed as such and indeed these women made great efforts to lose weight even though they were aware that they were battling against the odds.

A similar approach was demonstrated by the women who, while they did not interpret their fatness as genetic, felt that it was due to their having a slow metabolism. The majority of these women felt unable to accept that to be fat was probably the inevitable result of consuming

an average diet because of their slow metabolism. Rather than accepting this, they tried to change their weight, usually by consuming a very small amount of food daily. Several women reported an awareness that their metabolism had probably slowed down as a result of too many diets and tried to consume as little as possible daily in order to try to keep their weight under control. In effect these women could be seen to be on permanent restrictive diets. The following quotations are common examples of some of these women's attitudes and experiences regarding the physiological nature of their fatness:

> 'All the girls in my family are rather plumpish, well my brothers are too. It's a family failing. ... I've got a lazy metabolism. She [G.P.] said that if I wanted to lose weight I'd have to go down to about 800 calories to stimulate my body to lose weight and you can't eat much for 800 calories'
> (Helen Palmer).

> 'I've got a really slow metabolism, I need to eat very little to put on weight. So I only eat one meal a day really, in the evening'
> (Teresa Browne).

> 'Over the years I have got heavier and heavier. You end up with too many diets all the time, it's just too much... After every diet I've ended up heavier, just a little bit heavier and then you don't shift it. ... I never bother [cooking] for myself. I don't eat much at all really'
> (Susan Hartwell).

The extent to which these women's fatness was attributable to purely physiological factors cannot be, and indeed was not intended to be, ascertained from this research. Nevertheless, it seems clear that, in these women's accounts, physiology was viewed as having a part to play, both in causing and maintaining fatness. However, even though some degree of causality was attributed to physiology by the women this did not result in their accepting their size as inevitable. Rather,

attempts were still made, sometimes efforts of an extreme nature, to achieve and maintain slimness.

All of the other factors identified as causing or contributing to the women's fatness were related to eating in some way. These factors were not viewed by the women as being in any way physiological. No women felt that they overate because of some biological need that was out of their control. Rather, their eating, which they saw as causing or contributing to their fatness, was viewed as being an area that they did, or at least could, have control over. However, the fact was that they often did not, or could not, maintain this desired control over their food intake. This lack of control was, I would argue, directly related to social factors and it is these that I will now go on to discuss.

3.4(ii) Life Events

I have used the term 'life events' to cover a wide range of events and experiences identified by the women interviewed in the course of the research. Thus, life events in this context covers not only the large, disturbing or traumatic events such as illness, bereavement or divorce, but also those that are less disturbing but nevertheless bring about change, such as marriage or childbirth. In addition, the more routine stresses and strains inherent in women's day-to-day lives are included in this. There is a wide literature, as I have discussed in chapter one, linking stressful life events with physical and mental illness (Brown and Harris, 1978). In addition it is noted that there is a link between overeating and: disturbing or traumatic life events (Lipinski, 1975; Lowe and Fisher, 1983; Bradley, 1985); smaller stresses and strains experienced in everyday life (Abramson and Stinson, 1977; Roth,

1982; Slochower, 1983); and the stresses experienced by women as a result of their social roles (Orbach, 1978, 1984; Chernin, 1983; Cline and Lean, 1987). Many of these studies argue that overeating in the face of various forms of stress serves two purposes. First, it can be a source of comfort and so help the person to cope with stress, and, secondly, it can make the person feel she or he has some control in situations where it may seem that circumstances in their lives are very much beyond their control.

In the literature on life events and eating, then, the term 'life events' does not have one clearly defined meaning. There are different levels of interpretation of what constitutes a life event and how analysing or theorising about life events is best undertaken. In discussing life events, weight and eating in relation to my research, I will use a wide definition of the term 'life event'. The definitions and analysis used will be based on those employed by Brown and Harris (1978) in their study of depression. Three points will be focussed on in the analysis: first disturbing or traumatic life events both in childhood and adulthood and their association with eating; secondly, less dramatic or disturbing events but ones that nevertheless bring about change; and, thirdly, the stresses inherent in everday life. The latter area will be discussed in relation to the feminist arguments that such stresses are inherent to women's lives and that food and eating may be a common way of dealing with such stresses.

None of the women I interviewed reported any serious eating disorders such as compulsive eating or bulimia, nor indeed was there any evidence that such severe eating disorders, as defined and discussed in chapter one, existed amongst this group of women. However, as Charles

and Kerr (1988) have noted, such serious eating disorders are only one end of the continuum. They argue that all women have a problematic relationship with food, and because of this many women use food for means other than to relieve hunger. Thus, they argue, it is not unusual for women to display some form of 'eating disorder' or 'disturbed' eating patterns, although these may not be extreme. Certainly, while there was no evidence of serious eating disorders, there was some evidence of 'disturbed' eating patterns. The extent to which these disturbed eating patterns are a 'normal' response, both to stress and to the practical and ideological organisation of food and eating, will be seen in the following discussion.

A total of 13 women (35%) *reported* eating as a result of stressful life events or that they ate for comfort. However a far greater number, while they did not identify specific life events and did not use the term 'comfort eating', did report eating when they were fed-up, bored or lonely. In all, 30 women (81%) came into these two categories. Thus, the great majority of women in the study can be viewed as eating as a result, to some degree, of some form of stress. This, then, makes the area of life events (in its wide definition) and eating very important.

Several of the women interviewed had experienced a variety of disturbing and traumatic events during their childhood. Experiences such as parental divorce, adoption, being fostered, living in local authority residential care, sexual abuse and serious illness were all reported. Such experiences are obviously not confined to this group of women, and some of them may, in part, reflect the fact that the majority of the women were from working-class backgrounds. However, the uniqueness of these experiences is not the point in question; what is at

issue here is whether such experiences may have a relationship with eating and becoming fat. A total of 10 women (27%) had experiences in their childhood, that is before the age of 12, that can be viewed as extremely disturbing. Over two-thirds of these (n7) reported 'always' being overweight or being overweight since their childhood. This may indicate a connection between such stressful events and overeating leading to becoming fat.

However, while some women did report eating for comfort during periods of extreme distress in their childhood, others linked their eating patterns to their parents' or other adults' responses to their problems. Children, in general, do not have overall control over what they eat. While they may have some access to food or money to buy it, their main food intake is generally determined by the adults who look after them. There was some evidence from the interviews that while some of the women had turned to food as a source of comfort in response to distress in childhood, others had such patterns of eating inflicted on them by parents or other carers as a way of compensating for their unhappiness. The result of eating in response to distress in this way, whether it was started through an adult's encouragement or self-motivation, is likely to be the establishment of a pattern of eating that continues throughout an individual's life, and so may lead to becoming fat. This appears to be what happened in many of these women's cases. The following two cases are examples of how eating patterns that led to women becoming fat were established in response to distress and demonstrate how difficult it is to change these patterns in later life. In the first example, the woman's eating was self-motivated and in the second example it was established by an adult.

*Example one*: Mary Thompson.

Mary was taken into local authority care when she was a baby as a result of her parents neglect and spent virtually her entire childhood in care. She was sexually abused while in care and as a consequence was moved to another residential establishment when she was nine years old. In all, she lived in six different children's homes during her childhood. She was understandably a very unhappy child and she used to eat to make herself feel better. This meant that she got fat but she felt she could not change this behaviour as she found eating gave her some comfort. Her adolescence and adult life continued to be unhappy. She became pregnant when she was 15 but lost the baby. This pregnancy was followed by five more, four of which ended in miscarriage. She married when she was 17, but her marriage lasted only two years, and following this she cohabited with several men in succession, one of whom sexually abused her daughter resulting in her daughter being taken into care. All through this unhappy train of events, Mary continued to eat for comfort in the pattern that she established in childhood and she saw this as contributing to her being fat. About this she says:

> 'I'm definitely a comfort-eater. Even after I had Rebecca I'd always go and eat a lot if I was upset. I'd just scoff, just anything that was around, you know.'

*Example two:* Angela Downer.

Angela's parents separated when she was 11 and her new stepfather was violent towards the family. As a consequence Angela went to live with her grandmother and her brothers went into foster homes. When she went to live with her grandmother, Angela's diet changed completely. She recalled that her grandmother cooked large meals and frequently bought her sweets and chocolate. This was obviously an unhappy time for her and

she felt that her grandmother may have been trying to compensate for this with food. Angela attributes her problems with her weight as starting at this time. In her adult life, Angela has continued to eat when she has been upset. She says, for example:

> 'If I've had a row with my husband, that's when I do tend to eat more, if we've had an argument'.

These two examples illustrate how eating patterns can be established in response to stress in childhood and how, once established, such patterns can be very difficult to break.

Obviously a child's eating patterns are very much influenced by its parents and such patterns are likely to be very hard to break in adulthood. Indeed, much of the literature on eating problems notes that 'disturbed' patterns of eating in adulthood are often caused by parents feeding children in response to emotional rather than physical needs (Bruch, 1974). Certainly, many of the women interviewed noted that, while the types of food that they ate might have changed on leaving home, the timing and amounts consumed in meals and snacks in general remained the same, and this may indicate the importance of parents in establishing eating patterns. However, I would argue that there are other factors that influence eating patterns in adulthood and that women eating in response to stress in adulthood do not do so just as a result of eating behaviour learnt from their parents, although this may be a factor. Factors that may influence an adult woman's diet and encourage her to eat in response to stress are related to the practical and ideological organisation of food and eating and to the problems brought about by constant dieting. These will be discussed in greater detail below but it is important to note their influence here. When viewed in

this light, stress eating in adulthood can be seen as being influenced by wider social factors in addition to learnt eating patterns.

As with the incidence of disturbing life events experienced in childhood, there were a number of women who experienced disturbing life events in adulthood. The most common types of events were: loss of a child through miscarriage, stillbirth or neo-natal death; bereavement; divorce, separation or the break-up of a long-term relationship; homelessness or other housing difficulties; illness; pregnancy before the age of 16; and loss of employment. The definition of what is and what is not a disturbing life event is a contentious issue and obviously a broad definition will mean that a larger number of women will be viewed as experiencing such an event than a more narrow one would. In defining the number of women experiencing a disturbing life event here I have kept to a fairly narrow definition and have included only the events listed above. These are experiences that can be viewed as traumatic *events* and not just long-term difficulties associated with day-to-day living. Using this definition, a total of 20 women (54%) experienced disturbing life events in adulthood. Again, the high incidence of events such as homelessness and teenage pregnancy in this group of women may reflect, in part, their social class composition. As with the response to disturbing life events in childhood, many of the women responded by turning to food for comfort as the following two examples illustrate. The first woman is talking about her response to her child being stillborn and the second to repeatedly losing her jobs.

> 'If I'm feeling down it's the fridge or the cupboard I'll go to and after the stillbirth I just couldn't worry about it [putting on weight] because I just felt so awful'
> (Helen Palmer).

> 'I would really have liked to have a proper job, but, um, I just wasn't lucky enough. They've just never worked out, I don't know why ... I think all these problems with my jobs made me want to eat because I do eat when I'm stressed'
> (Judith Osborne).

These two examples, then, show how food can offer some comfort to women in times of extreme distress.

Some of the interviewees, however, noted that distress had the opposite effect on them. These women noted that they ate when they were happy but that distressing or unhappy events caused them to be unable to eat. One woman, for example, reported that she lost a lot of weight when her husband, who was in the army, was away in the Falklands, but that when he came home again she put it all back on. Other women noted that when they were in relationships with men they put on weight because they felt happy, but when these relationships broke up they lost weight. Furthermore, several women reported that they put on a lot of weight when they got married and they linked this to feelings of contentment leading to overeating. There certainly appears to be some evidence for the view that events that lead to significant *changes* in women's lives, whether these changes be viewed as good or bad, have an impact on eating. Some writers have argued that women alter their eating patterns when they feel that their lives are out of their control in some way in order to give themselves a feeling of control in one area of their lives at least (Charles and Kerr, 1988). Such changes in eating patterns may be to not eat or, alternatively, to overeat. This type of response is clearly evident in the women interviewed, and indicates some association between life events or stress and eating.

So far I have looked at life events that have been disturbing or have brought about significant changes in women's lives. However, it is also important here to look at day-to-day stresses that may lead women to overeat as a means of coping. The use of a broad definition of stressful life events that incorporates day-to-day difficulties such as being in an unhappy relationship, job dissatisfaction, feeling isolated or bored because of one's social situation, or experiencing an unplanned pregnancy, means that the majority of the women can be characterised as experiencing stress. This type of definition would entail 26 of the women (70%) being in this category as a result of self-reporting of stress or unhappiness in their lives. It may be that this figure should in reality be even higher, given that it is based purely on the self-reporting of stress which may underplay its true extent.

There is some literature relating the experience of stress to women's oppression (Busfield, 1988). Furthermore much of the feminist literature on eating notes that the sorts of stresses that lead women to develop eating problems are the everyday stresses that are inherent in their social roles (Orbach, 1978, 1984). There seems to be considerable evidence from this research to support this theory. Many of the everyday stresses identified by the women are those that exist purely as a result of their social roles. For example, those women with children and no paid employment expressed feelings ranging from dissatisfaction to unhappiness regarding their social roles as mothers and housewives. Feelings of being tied to the home, of having little or no adult company, of having no social life or interests outside of the home, and of being responsible for all household and domestic work in the home were common. Women without children who had been in paid employment in

the earlier part of their present pregnancy also expressed dissatisfaction relating to the social roles associated with being female. Working the 'double shift' of paid work outside the home and unpaid housework within it with little 'help' from partners was a common problem. Many women in this group too noted their lack of a social life both because of constraints of time, money and society. As a result, feelings of resentment and powerlessness regarding their social situation were common. I noted above that 30 women reported that they ate when they were bored, lonely or fed-up. However, these feelings of loneliness, boredom and dissatisfaction are not isolated incidents reducible to individual psychology but very much connected to women's structural position. The finding that women turn to food when they feel this way is a clear indication that, at least for this group of women, food is used as a way of coping with inherently stressful lives. The following example illustrates this:

> 'Boredom definitely makes me want to eat more. Often during the day when I'm on my own. Especially towards the end of the week when the housework's done, the washing and ironing's done and I sit and I think: well, what shall I do now? There's nothing on the telly except for some Australian soap and I think: well, I'll go and raid the larder'
> (Louise Marsden).

For this group of women, at this particular stage of the life cycle, the type of feelings engendered by their social roles are ones of boredom and isolation. For women at other stages, different types of feelings relating to their oppression might be dominant, any of which might lead to food being used for comfort. Obviously not all women who turn to food in this way become fat but, for the women in this study, stress can be seen as a predisposing factor contributing to their becoming and

remaining fat. Given the association between stress (broadly defined) and eating, it is important to ask why food is used in this way. This question can be addressed through a discussion of the other two areas that were identified above in Table 9 as causing or contributing to women's fatness: the practical and ideological organisation of food and eating.

There are several aspects relating to the practical or ideological organisation of food and eating that may contribute to making a woman fat in the first place, or may make losing weight in the long term difficult. By the practical organisation of food and eating, I mean the practical day-to-day factors such as time or money that may constrain or indeed determine the constituents and the timing of food consumption. The ideological organisation of food and eating, on the other hand, relates to the customs and practices surrounding food and eating in families which are not practically determined, but ideologically or culturally determined. These factors are, as I have noted in chapter one, discussed at length in the literature on the social aspects of food and eating (see Murcott, 1982a; Kerr and Charles, 1986). The practical and ideological constraints or determinants of food and eating are not necessarily separate categories, and in many cases these aspects cut across each other. However, here I will be discussing the areas separately where this is possible.

### 3.4(iii) The Practical Organisation Of Food And Eating

The majority of women noted that they experienced some constraints, either practical or ideological, which determined their diet. A total of 23 women (62%) noted that these constraints were a result of mainly

practical factors. Some of these had occurred in the past and were seen as contributing to the women becoming fat; others were ongoing and were seen as contributing to their remaining fat. The factors in the category of practical constraints that I want to discuss here involve issues of time, money, employment and access to cooking facilities.

All of the women in this group (n23) had some conception about what a 'good' diet should comprise. In general, the constituents of a 'good' diet were seen to be fresh fruit and vegetables, and some women added to this list various high fibre and/or low fat foods. The identification of such foods as 'good' corresponds to current nutritional thinking which has been widely publicised in the media (Gilbert, 1989; Calnan, 1990). That such foods were identified as necessary for a good diet is unsurprising. However, many women reported that, while they were aware of the sorts of foods they 'should' eat, in reality their diet was, or had been in the past, quite poor. This was not only because they did not consume the sorts of foods that they viewed as 'good' but because they consumed the types of foods that they viewed as 'bad'. It is interesting to note that all the foods characterised by the women as 'good' were ones that are associated with slimming and weight-reducing diets, whereas the foods characterised as 'bad' (for example, fried foods) were the ones that were viewed as fattening and associated with weight gain. A similar finding was noted by Charles and Kerr (1988) in their study of women and food. The significance of this in terms of this study is that, for these women, a 'bad' diet is not primarily one that is unhealthy, but rather one that is likely to lead to weight gain. Thus, when these women talked about practical constraints leading to a bad diet, they meant a diet that was fattening and that might lead them

to put on weight. 'Bad' in this context can be interpreted as fattening, not necessarily unhealthy. Notions of healthiness are of secondary importance to these women, for whom bodysize was the most important factor.

All of the women in this group (n23) reported that their diet was, or had been at one time, 'bad'; eleven women noted that their diet was bad immediately before their pregnancy and the other twelve women that it had been bad in the past. The 'badness' of their diet was seen as contributing, in many cases, to their being fat. The reasons for consuming such a diet were seen to be as a result of practical constraints that made the consumption of a more healthy diet difficult. The most commonly reported constraints were related to employment in some way. A total of twenty women reported this. Ten women noted that their employment meant that they were constrained in terms of time to prepare, cook and eat meals and a further ten women felt that the sorts of jobs they had constrained their diet.

That a number of women found employment led to constraints of time in which to prepare, cook and eat food relates, in part, to the ideological organisation of food and eating and this will be discussed below. Women are seen as being primarily responsible for buying, preparing and cooking food even when they have no more time available to do this than their partner. While there has been some notion recently of a move towards greater equality in the sharing of household tasks between spouses, particularly when both partners are in full-time employment, many studies have found that such sharing exists more in theory than in reality (Mansfield and Collard, 1988). Indeed, the great majority of women in this study had primary, if not sole, responsibility

for preparing and cooking food and this coupled with their full-time employment meant, for these women, that they consumed a diet that they felt was poor. It resulted in their consuming a lot of frozen 'convenience' meals, fried foods and take-away meals, all of which were viewed as unhealthy and many of which were viewed as 'fattening'. The following comment regarding this was common:

> 'Just before I became pregnant we were living a fairly unhealthy diet because, basically, I was working long hours, I was working until about 8 at night and so it was easier to chuck some chips in the oven, some sausages or whatever when I got home and it's ready in 20 minutes sort of thing. I enjoy a decent meal but I couldn't be bothered because I was just too tired to do it'
> (Margaret Marshall).

As well as employment bringing constraints of time resulting in what was viewed as a poor diet, several women noted that the jobs they did actually led to their consuming a bad diet *at work*. Seven women were, or had been, employed in the catering trade and thus were in constant close contact with food. All of these women noted that they put on a lot of weight during their periods of employment and some women saw this as the primary cause of their original fatness. They felt both the temptation to 'pick' at food while working and also the types of meals that they were given while on duty were the cause of the problem. A further three women identified a similar problem. These women were employed in 'caring' employment working as nursery nurses or carers in children's homes or schools. In these types of employment, meals are eaten on duty and, again, little control or choice over this is possible. These women too noted that the sorts of foods that they ate at work were not those that they would have chosen and were often viewed as unhealthy and fattening. Given that the sorts of employment areas in

which women are traditionally employed are ones where contact with food in some way is common, this may be an important contributory factor leading to some women becoming or remaining fat. Being employed in areas that are not directly related to food, however, may also contribute to a woman becoming or remaining fat. Some women noted that the lack of choice in staff canteens and the use of food as a means of breaking up the day in boring and monotonous jobs contributed to their being fat and made changing their size difficult.

Another factor that several women identified as a determinant of their diet, and one that often caused them to eat unhealthy or fattening foods, was income. There have been several studies showing that working-class people on low incomes have a poor diet and that this may lead to their becoming fat or finding difficulties in losing weight (Cole-Hamilton and Lang, 1986; Graham, 1986). Consumption of what is seen as a 'healthy' diet is not necessarily expensive. Indeed, some writers have argued that a healthy vegetarian diet is actually much cheaper than a meat-eating diet. However, given that the 'dominant food ideology', that is, the dominant cultural view of what constitutes a proper diet, is one that contains meat, the consumption of a purely vegetarian diet is not widespread practice (Twigg, 1983). Thus, the consumption of what are seen as 'healthy' foods have to be added into the diet, thereby creating greater expenditure. Notions of what constitutes a proper diet may also be dependent on social class. Food such as cakes and biscuits, although expensive, may be seen as basic to the diet of some families. Where income is low, such families may buy these foods first, thus leaving no money for other more 'healthy' foods. Thus, although a more healthy and less fattening diet probably *could* be

afforded by many people, the way foods in particular households are prioritised may prevent this (see Calnan, 1990). The following example illustrates how income was viewed by some women as affecting diet:

> 'We eat too much fried food. We never eat fruit. It's one of those things people tell you, you should eat this, you should eat that, which is alright if you've got a never-ending cheque to go round and buy it all, because fruit and things are expensive. You know, stick a couple of pounds of apples on the bill and that's another pound [in money] gone. Sometimes we go through a stage and we say we've got to sort out our eating and we'll start eating better, but after you've done it for a week you think, oh, you know, the food bill goes sky high'
> (Louise Marsden).

Another practical constraint determining the diet of some of the women, either now or in the past, was their housing. Six women were living in the parental home immediately before and during their present pregnancy and consequently had little control over their diet. These women had to consume what their mothers had cooked for the family meals, which was not necessarily what they themselves would have preferred. Trying to diet or restrict food intake in such a situation was identified as difficult. Several others saw their past housing position as a causal factor in their becoming fat in the first place. Living with parents, parents-in-law, friends or relatives, or sharing cooking facilities with others meant for some women that their diet was not all that they might have wished it to have been.

These then are the practical factors identified by the women as important in causing them to be fat in the first place and in making it difficult to become slim. While these factors have been termed practical this does not mean that they can be understood solely as isolated practical difficulties experienced by individual women. On the

contrary, these difficulties are social in origin and reflect the way society is organised. The fact that it is women who are primarily responsible for food preparation reflects their subordinate position in society as the handmaidens of men. In part, too, the factors identified reflect the social class divisions in society. It is working-class women who are most likely to be living on low incomes and/or in difficult housing conditions and who, as a consequence, are most likely to consume a poor diet. The factors identified, then, have a social basis and reflect gender and class positions in our society. It is women, and particularly working-class women, who are most likely to experience these practical constraints on their diet and this may be reflected in the social class composition of the sample in this research. However, of course not all women will have a similar outcome from such dietary constraints as these women have. While this group of fat women have identified these factors as contributing to their becoming or remaining fat, others with similar experiences may remain slim. Certainly, for these women, there appears to be some association with the above practical factors and becoming fat. These can probably best be seen as predisposing factors acting along with other factors in contributing to these women becoming and remaining fat.

3.4(iv) Ideological Aspects Of Food And Eating

The organisation of food and eating in households is not determined solely by practical factors. There are in addition, as I have noted above, ideological factors that surround food and eating. The literature on this topic argues that the ideology that surrounds food and eating is a familial ideology that both reflects and reinforces the

sexual division of labour and patriarchal power relations (Murcott, 1983, 1987; Charles and Kerr, 1986a,1988). This ideology is seen as evident in the cultural customs and practices which, to a large degree, determine what food we eat, who prepares and serves it, and how, where and when we eat it. I want here to examine first, the nature of the customs and practices surrounding food and eating and secondly, the way that these affect women's diet and thereby might contribute to women becoming or remaining fat.

The patriarchal family relations regarding food and eating that Charles and Kerr (1988) identified were also evident in this research. The clearest indication of their existence was revealed through an examination of the sexual division of labour in the home. Nearly all the women were primarily responsible for all or most of the domestic work in the home and integral to this was responsibility for meal preparation. In fact, of the 31 women living with their partners at the time of the interview, 22 women were *completely* responsible for all domestic work in the home (excluding cooking) and only 9 women reported *any* sharing of such tasks at all. Of the group of women who did note some sharing of tasks, five women were expecting their first baby and had only very recently left full-time employment. It is possible that the organisation of domestic tasks for these women might be subject to some change as they became more firmly entrenched in their role as full-time mother/housewife. The other women in this group were all middle-class, and this greater degree of sharing of household tasks among middle-class couples has been noted in other research (see Charles and Kerr, 1988). In terms of meal preparation, the division of labour was even more marked. Of the 31 women living with their partners, 25 women

were *completely* responsible for all cooking in the home and only 6 women noted any sharing of cooking tasks. The only relief from this responsibility, it seemed, was if they were ill and then their partners would take over responsibility for cooking for the duration of their illness.

It has been argued that this sharp division of labour between men and women occurs most commonly amongst couples at this stage in their life cycle, that is, among couples who have, or who are about to have, young dependent children and where the woman is a full-time mother and housewife. It is argued that the sexual division of labour in the home at this point represents the 'conjugal contract' that exists between men and women (see Murcott, 1987). This conjugal contract takes the form of an understanding between men and women, that women will provide men with domestic services in the home in return for their partners going out to work and earning money to keep them. There was some evidence from this research that leaving paid employment and being dependent for money on their partner's wage did give rise to this 'conjugal contract'. Several of the women interviewed had recently left full-time paid employment and they noted a change in the division of domestic tasks in the home. Such changes in responsibility in the domestic division of labour were viewed as 'right' and these were seen as a fair exchange for a partner's responsibilities at work as sole wage-earner. It is almost inevitable that the presence of the woman at home full-time will bring about changes in the organisation of domestic tasks because of her availability to carry out domestic tasks during the day while her partner is at work. However the complete role segregation that this appears to bring about is not a necessary condition of this.

Nevertheless, several women spoke of their 'job', once they had left full-time employment, as being solely responsible for domestic work, and of their partner's being to earn the wage:

> 'I do it all [domestic work] because he works and he brings in the money. I mean he does work hard ... and I think the least I can do is make sure the house is clean and tidy especially as I'm at home doing nothing. I'll put my bit in and make sure he's got that hot meal on the table'
> (Brenda Gray).
>
> 'When I was working we sort of took turns ... he'd do his fair share ... but now he just goes out to work and earns the money and I stay home and keep house.
> (Rachel Hardwick).

Thus, for the majority of women in this study, domestic work in the home was seen as being their primary responsibility and integral to this was responsibility for food preparation.

It would seem plausible to presume that being *responsible* for food provision in the home would mean that women would have control over the types of food that are eaten. However, the reverse seemed to be the case. While women appeared to have control over what was cooked, in that this was their responsibility, this control was illusory and proved to be merely control over the act of cooking, not over the choice of what was cooked. The women chose what food to cook at mealtimes but this choice was invariably not made with reference to their own food preferences but to the food preferences of others. The reason for this is likely to be twofold. First, because women are viewed, and view themselves, as responsible for the family's health and happiness at home, then they are likely to provide family members with the sorts of foods that they prefer. Secondly, women are socialised into putting others needs before their own and, in particular, into viewing

themselves as subordinate to men and thus in relation to food are likely to put this into practice by subordinating their own food preferences to others, particularly their male partner. Thus if we view the customs and practices surrounding food and eating as a reflection of wider social relations, then this practice of women subordinating their needs to that of other family members is indicative of the low value both that women put on themselves and that society puts on women.

There was a definite prioritising of family members in women's choice of what foods to cook at mealtimes and this too reflects the relative social status of men, women and children. Of the 31 women living with partners at the time of the interview, there were no cases where women reported that the choice of menu for the main meal of the day was made with reference to what they (the women) specifically wanted or fancied. Thus, all of these women noted that the choice of main meal was made with reference to the food preferences of other family members. In the majority of cases, the family member whose food preferences were most considered was the male partner. Out of this group of 31 women, 22 women reported that their choice of food for the main meal of the day was determined, to some degree, with specific reference to their partner's food preferences. The majority of these women did not have children, but 9 of them did and still noted that it was their partner's food preferences and not their children's that was the main consideration in choosing menus. A further eight women with children reported choosing foods that fitted in with all the family. In only one case did a woman report that their child's food preferences dictated the diet of both of the adult members of the household.

The high incidence of prioritising the male partner's food preferences for the main meal of the day can be seen to reflect men's high position in the social and familial hierarchy and, conversely, women's low position in these areas. In addition, their stage in the life cycle and their economic dependence on their partners may contribute to these feelings. Indeed, feelings of lack of importance in relation to men with reference to food choice was clearly demonstrated by the women's comments. It became evident that in prioritising their partner's food preferences women would not only subordinate their own preferences, but would actually cook food they did not like and either go without eating the main meal themselves or eat it even though they did not really like it. One woman, for example, didn't like to eat meat, but nevertheless cooked it for the rest of the family because her husband liked it and ate just potatoes and vegetables for her main meal. At the other end of the scale, another woman cooked all vegetarian food for her husband and consumed this too herself, although she was not a vegetarian and liked to eat meat. The following comment was a typical example of the commonly held view that men should be privileged in terms of menu choice for the main meal of the day:

> 'I cook for him [her partner] really, things he wants. I mean he loves sausages and I'm not very keen on sausages but I have them because he likes them'
> (Amanda Spelling).

The prioritising of the male partner's food preferences in choosing menus for the family, however, occurred only for meals that he would be present for. In general, the male partner was present for only one meal a day (apart from at weekends) and this was generally viewed as the main meal of the day and was usually consumed in the early evening. This

meal was viewed by the women as the most important meal of the day and was surrounded by certain rituals and rules of behaviour: it contained foods that the male partner preferred; it was timed for his homecoming from work; it was eaten with all family members present, ideally around a table; and, the behaviour of family members at this meal was generally that set down by the male partner who was 'in charge' during the meal.

The impact of the presence of the male partner, both on the content of the women's diet and on the rituals surrounding the eating of food, were evident from discussions regarding meals at which partners were not present. Women identified the mid-day meal, at which the male partner was not usually present to be a very different meal to the main meal of the day. In addition, women whose partners regularly spent periods away from home noted that their 'main' meal of the day was very different when partners were absent than when they were at home. Where women had pre-school children at home during the day, their mid-day meal was generally determined by what the children wanted to eat rather than by what the women wanted. Similarly, women with children noted that when their husbands were away from home the main evening meal was chosen with reference to their children's food preferences rather than their own. Many women without children noted that they 'couldn't be bothered' to prepare meals for themselves if their partners were away and would have a snack instead. As well as the content of food being different when partners were absent, so too was the way it was eaten. Meals without the male partner were much less formal affairs. They were often eaten away from the table, sometimes while watching television, and were not

bound by the strict rules of behaviour intrinsic to 'proper' family mealtimes.

Similar findings have emerged from other research in this area which has identified that, for example, single-parent families rarely follow traditional patterns of mealtimes (Charles and Kerr, 1986b). The following example is illustrative of both the prioritising of children's food preferences when partners are absent and the difference between these meals and ones where the partner is present. This woman's partner was a merchant seaman and so spent regular hours away from home:

> 'When the children get home I ask them what they want and they look through the freezer or the cupboard and they say "Oh I want this" and that's what I give them. ... The kids don't like it when he's home because he makes them eat their dinner. When I'm here I say "Here's your dinner" and they pick at it and then they say "We've had enough now" and they're off. When he's home he says "You've got to eat more than that" and he shouts at them and they cry because they don't want to eat it. It's awful. They're just used to eating what they want' (Susan Hartwell).

As Charles and Kerr (1988) have noted, the finding that mealtimes without the male partner present are different to when he is present demonstrates two things. First, it demonstrates the great importance attached to traditional family meals as a way of symbolising the ideal of family life. Secondly, it demonstrates the relative social status and importance of the people present. The prioritising by women in terms of food, of men first, followed by children, can be seen to reflect wider social structures.

In this discussion of the ideological organisation of food and eating I have focussed on the 31 women in the sample who were living with partners before their pregnancies. Some mention should be made

here of the remaining six women in the study who lived either alone or with their parents before pregnancy and the impact that the ideological organisation of food and eating had on their diets. Before becoming pregnant, four of these women lived in their parental homes and two lived independently, one lived with her sister and one lived alone. One of the women who lived in her parent's house had similar experiences to those discussed above. This woman lived with her father and, as the only female member of the household, she took on the role of wife. The situation of the other three women living with their parents was quite different. They were viewed as the children of the household and as a result did not have primary responsibility for meal preparation. However, neither did they have choice over the content of meals and this may have been a factor contributing to their size. The two women who lived independently of their parents had the greatest freedom and choice over the organisation of food and eating. However, constraints of time and money had a strong influence on the diets of both these women.

It is important now to go on to examine the effect that the food practices described above had on the women who were living with partners and how these may have contributed to their becoming or remaining fat. The discussion above has identified two major areas in the organisation of eating in the home that are likely to affect women's food consumption. First, there is the practice of prioritising the food preferences of the male partner and the children in choosing what food the family should eat. Secondly, the rituals surrounding mealtimes and the extent to which these symbolise family life may also be important. In reality the effects that these two areas have on women's food consuption are inter-related. For example, a woman may cook the types

of food that her husband prefers but this by itself does not mean that she too must eat this food. What makes the likelihood of her consuming the same meals as her partner so great is the ideology that surrounds 'family' mealtimes. I have already discussed, above, how the majority of women in this study had their diet shaped by their partner's or children's food preferences and, furthermore, that the majority adhered to the dominant familial ideology surrounding food and eating in terms of mealtime rituals. Thus, such factors had an obvious effect on women's diets in that the majority were consuming a diet that was, for the most part, not of their own choosing.

However, the question here is whether this resulted in these women becoming or remaining fat. Out of the 31 women living with their partners at the time of the interview, 15 stated that catering for their partner's or children's food preferences contributed in some way to their becoming fat or made dieting difficult and therefore contributed to their remaining fat. It may be that this number could, in practice, have been even higher. No women were asked directly whether they felt that the eating preferences of the family contributed to their becoming or remaining fat and, given the strength of the ideology surrounding family eating practices, it might be that some women would feel reluctant to volunteer this as a cause of their fatness. The women who did note that family members' food preferences contributed in some way to their fatness identified four areas in which this was so: first, through having food in the house for family members that the women wanted to avoid because it was viewed as 'fattening'; secondly, through viewing family mealtimes with partners and/or family as social events which, they felt, led to their overeating; thirdly, through consuming

food at mealtimes that was viewed as fattening because this was the food preferred by a partner or other family member; and fourthly, through being unable to diet because of the necessity of cooking for family members.

Several women noted that it was not necessarily consuming the wrong types of foods or overeating at mealtimes that contributed to their fatness, but rather what they ate between meals. However, although this eating between meals often took place when the woman was alone, it was not unrelated to the food preferences of others. It was noted that catering to the food preferences of family members entailed having food in the house that they wanted to avoid because it was fattening. Such foods were identified as cakes, biscuits, chocolate and crisps. These foods were bought because partners or children particularly liked them and they were often used by the women in preparing packed lunches for family members to take to work or school. Food shopping in these families was invariably done on a weekly basis and there was, therefore, often a large supply of these items in the house. The result of having an abundant supply of these 'forbidden' items readily available was that women could not resist having 'just one', and several women noted that one often was not enough so that they would go back for more until they had finished them all. In addition, where these items were handled by the women on a daily basis in preparing packed lunches, the temptation to eat them was noted to be hard to resist. Several women reported that they craved these sorts of foods anyway and the only way that they could resist eating them would be not to have them in the house at all. Thus, for these women having 'fattening' foods in the house was seen as a

contributory factor both in causing fatness and in making weight loss difficult.

Another factor identified as contributory to fatness and difficulties with weight loss was the social nature of eating and mealtimes. I have already noted that several women reported that their weight increased upon marriage or co-habitiation. Before this, eating was often viewed as a necessary functional exercise that had to be got out of the way before getting on with more important things. However, upon marriage or cohabitation eating took on significance as a social event: it was a way of spending time together and sharing in an enjoyable pastime. Additionally, the act of cooking for male partners was seen as a way of demonstrating care and affection. Several women noted that eating and mealtimes as shared social activities with partners led to their eating more than they used to and therefore contributed to weight gain. Where this was noted as occurring, the women did not blame their partners for it. It was not acknowledged in a negative way that they might be eating more because they were catering to their partner's food preferences or because eating was a way of spending time together. Rather, it was felt that eating was an enjoyable social activity that the couple shared. Acknowledging the cause, or one of them, of their fatness did not, however, help these women in trying to lose weight. Attempts to lose weight were still made by these women but, as will be discussed below, these were very difficult because of the importance of the impact of the social nature of eating described above. The following quotation from one of the interviewees demonstrates both how having a partner's preferred food in

the house and how, following marriage, eating as a social activity can contribute to becoming and remaining fat:

> 'My appetite has definitely increased since I've been married. I think it was him [partner] encouraging me to eat. I just never thought about eating before, I just never had the time. I wouldn't have dreamt of eating biscuits or cakes before I got married. I wouldn't have thought about it at all. My mum's never bought them and I never thought about them. But John's a big sweet person so we have those things now. ... We love our food, we really enjoy eating. Because at home it was mainly me and my mum and I was always getting ready to go out and I just used to eat my dinner on a tray in front of the television. So me and John, we like to sit round the table talking'
> (Carol Smith).

For this woman, living with her partner had resulted in a marked increase in consumption. This was due to both consuming the sort of diet her partner preferred and to eating having become a shared social activity. The above comment was similar to those made by other women in this study.

A further factor identified by some women as contributing to their becoming or remaining fat was that of cooking and eating their partner's preferred foods where it was acknowledged that these foods were fattening. Such foods were identified most commonly as fried foods which were frequently mentioned as favourite foods of male partners. The difference between this and the more 'social' overeating with a partner, discussed in the preceding paragraph, is that there, partners were not held responsible, or where they were, were not *blamed* for a woman's overeating leading to her becoming fat. In this type of eating, however, the women acknowledged that it was because of their partners that they were eating a particular diet and that this led to their eating the sorts of meals that would result in weight gain or make

weight loss difficult. While all the women conformed to the view that they should cook meals that their partners preferred, this was seen as problematic when these foods were viewed as fattening. In such cases, however,the women did not feel resentment at having to cook meals that coincided with their partner's food preferences, but rather felt resentment that their partner's food preferences were for fattening foods. Nevertheless, they still felt it was necessary for them to prepare meals that coincided with their partner's preferences.

The women identified the only possible solution to this problem as being to cook two separate meals, one consisting of the male partner's preferred foods and one of the woman's preferred foods. However, there were several factors that militated against this. First, constraints of time for many women, particularly those in full-time employment, often meant that cooking two separate meals just was not possible. Secondly, some women felt they did not want to go to the bother of preparing two separate meals a day and having two separate lots of washing up. Thirdly, some women with young children noted that both partners having different meals made mealtimes problematic as it led to children being fussy about their meal. Finally, it was noted that the 'social' element of meals, discussed above, was missing where partners consumed different meals and often resulted in partners eating at different times or places. Thus, for many women, these constraints often resulted in their continuing to cook and eat the preferred foods of their partners even though these were viewed as fattening. Many of these women felt in an impossible situation where they were very unhappy about their size and wanted to lose weight but were unable to do anything about it. As one woman said:

'With my husband it's just fried food and nothing else. Like, you could put a roast dinner in front of him and he'd hardly touch it and yet if I gave him, on a Sunday, a plate of chips and a load of fried stuff, he'd eat the lot. I have tried to get him used to different things, but if after seven years I can't, I don't think I ever will. It's so hard, I feel I'm stuck in the middle sometimes because my daughter doesn't eat a lot of chips. She would rather have something with gravy and a bit of meat of some sort, but you know I feel I can't cook these different meals and Bob has been out to work all day and he should be able to come home and have something he likes. ... So I think I'm just going to have to suffer and you know just have what he has and try to get my body used to having smaller amounts'
(Angela Downer).

The final area identified by the women focussed on the difficulties in losing weight through dieting because of the organisation of family mealtimes. In part, this area has been addressed in the preceding paragraph. Constraints of time and energy as well as the social element of mealtimes make it difficult to consume meals that are different to those consumed by other family members. However, there are a number of additional factors relating specifically to dieting that are relevant here. The majority of women in the study had attempted a weight reducing diet at some time in their adult life. In fact, of the 31 women living with partners at the time of the interview, all but one had attempted at least one diet in adulthood. A wide variety of diets had been attempted by the women. Many had tried the recently popular 'Microdiet' or 'Cambridge Diet' which consists of a meal replacement drink, but these, like the other frequently mentioned 'faddy' diets such as grapefruit or egg diets, were seen as largely unsuccessful because once 'normal' eating was resumed any weight lost was quickly regained. More successful diets were viewed as being those that involved cutting down on food or eating a low calorie diet, particularly where these

diets were given as part of a weight loss programme from a slimming club such as 'WeightWatchers'. However, many women noted that even these dieting attempts were often short-lived and one of the major reasons for this was seen to be the complete responsibility that women have for food preparation.

For women who are full-time mothers and/or housewives, food is a major daily pre-occupation. Much of their day is spent thinking what to cook for meals, shopping for food, preparing it, cooking it or clearing up afterwards. Each of these tasks makes trying to diet difficult. Having to spend such a large part of the day thinking and planning how family members' food preferences can be indulged through the cooking of interesting and satisfying foods, yet at the same time having to think of their own daily food intake in terms of constraint, is obviously problematic. The very act of eating a small and unexciting 'diet' meal in the company of others who are eating a more exciting 'proper' meal is likely to be difficult. In addition, many women noted that partners were generally unhelpful and unsupportive of their dieting attempts. It was rare for partners to offer to eat different types of meals that were more in line with dieting foods to make both the preparation and eating of meals more easy for the women. Similarly, requests for help that would make adherence to a diet more easy were often ignored. One woman asked her partner to throw away any food left on his plate at the end of the meal as she found it tempting to finish it off when she was clearing the table, but this request was completely ignored. It was noted too by several women that their partners would sometimes bring them home chocolates or suggest a 'take-away' meal even though they knew that they were dieting. It seemed that although men often expressed a desire for

their partners to lose weight, they were not prepared to change their lifestyle in order to make it easier for the women to bring this about. The likelihood of diets being persisted with in these sorts of conditions is slight.

In addition to these problems, several women noted that dieting and the denial of food, in conjunction with their close contact with food, led to other problems. It was noted that long-term deprivation of particular foods often led to women craving such foods. The result of this often was that a diet was broken by having a 'binge' on the types of foods they had been denying themselves. Once the diet had been broken in this way the women often felt very guilty about it and made plans to re-start the diet as soon as possible. This dieting-indulging cycle was a common feature of many of the women's experiences regarding diets and obviously the close contact that women have with food is significantly contributory to this. This pattern of repeated dieting, because it is generally unsuccessful, is not likely to lead to the desired weight loss. In addition, as I have noted above, it has been linked to weight problems which may occur as a result of metabolic disturbance caused by repeated dieting. The following two quotations give examples of the patterns of dieting followed by indulging that were identified by the women:

> 'Usually after dieting it ends with eating all the things that I wasn't allowed to eat during the diet'
> (Fiona Tindall).

> 'My favourite thing was that I'd start a diet Monday, but before Monday I'd stuff like mad, especially Sunday night, and Monday would come and I'd start to diet but by Monday evening, I'd given up, I was back to square one. And then I'd sleep on it and I'd get really upset at night and I'd think: I'm going to do it, I'm going to do it and I'd set a goal for myself of when I was going to do it. And then I'd stuff myself like mad again and I

> wouldn't do it. So it was a continual pattern of stuffing myself before this diet that never happened' (Mary Thompson).

It can be seen that women's close contact with food makes attempting a diet in the first place very difficult. In addition, where women do attempt to follow diets, these are often unsuccessful in the long term due to, in part, the constant temptations to eat 'forbidden' foods that arise from their daily responsibility for meal preparation.'

## 3.5 CONCLUSION

This concludes the section looking at the predisposing factors that can lead women to become or remain fat. The experiences identified as relating to these factors may be common to women of various shapes and sizes. However, in the cases of the women in this study, these factors were viewed as contributing to their becoming or remaining fat and it is this that makes them problematic for these women in particular. The data collected led to the identification of four major predisposing factors: first, physiological factors; secondly, factors relating to stress and life events; thirdly, factors relating to the practical organisation of food and eating; and fourthly, factors relating to the ideological organisation of food and eating. As I have noted above, these factors are not intended to be viewed as mutually exclusive; rather, many women reported a variety of factors as contributing to their becoming or remaining fat. What becomes clear from this, and the preceding discussion on the women's feelings about their size, is that while the great majority of women felt dissatisfied about their weight, they were largely powerless to do anything about it in the long term.

As I have noted above, fatness for women is a stigmatised condition which often leads to feelings of low self-worth and low self-esteem. However, preventing themselves becoming fat in the first place and, once fat, attempting to become slim appear almost impossible tasks for the reasons discussed above. Many of the reasons relate to social factors. In particular, women's social roles as wives and mothers have been seen to be important both in leading women to overeat in response to stress and in giving them opportunity to eat, or overeat, as a result of their close and constant contact with food. Changing these women's situation so that they had less reason or opportunity to overeat would entail a complete overhaul of the social position of women and thus the possibility of these women being able to change their size is unlikely. Where reasons for fatness are seen as being more physiological in origin, changing and becoming slim is an equally remote possibility. Indeed, in such cases weight loss is probably undesirable from a health point of view given that it could often be achieved only by a very low food intake. However, even though once fat changing their size was acknowledged as a remote possibility, this did not deter women from trying. As I have noted, virtually all the women in this study had attempted diets at one time and many dieted on and off almost constantly. That this occurred illustrates the intensity to which women felt dissatisfied with their size.

Using the areas discussed in this chapter I now intend to go on to examine what the experience of pregnancy was like for these fat women. The following points are of relevance in examining this: first, the great majority of the women were dissatisfied with their weight before their pregnancies commenced; secondly, most had a long history of

dieting attempts; and thirdly, the women's daily food consumption was determined, to some degree, by their social roles. Pregnancy may be a time of crisis for fat women who are already dissatisfied with their weight given that it involves almost inevitable weight gains, bodily changes and changes in diet. Just what changes occurred in the women's feelings and experiences regarding weight and eating in pregnancy, from those discussed above of pre-pregnancy, is the area to which I will now turn.

## CHAPTER FOUR: FEELINGS AND EXPERIENCES REGARDING WEIGHT AND EATING DURING PREGNANCY

### 4.1 INTRODUCTION

While the women in this study started off pregnancy from different weights, they all attained the weight of *at least* 90kg. by the 30th week of pregnancy. The focus of this study was intended to be on subjective feelings and experiences of fat women before, during and after pregnancy, rather than on objective factors of weight gain or loss occurring during these periods. However, I felt that it was important that some note was taken of objective facts of weight as these are likely to have an impact on experience. The details of the women's weights were sometimes obtained from self-reporting of interviewees and therefore were not necessarily entirely accurate. However, given the nature of this research and its focus on women's experiences rather than quantifiable facts, I did not feel that the use of approximate weights here was a problem. The following table shows the women's weights at approximately 30 weeks pregnant.

Table 10

Interviewees' Weights and Heights At 30 Weeks Pregnant

| | Height | | | |
|---|---|---|---|---|
| | 157-165cms. | 166-171cms. | 172cms.+ | Total |
| Weight: | | | | |
| 90-99kg. | 8 | 10 | 3 | 21 |
| 100-105kg. | 1 | 4 | 1 | 6 |
| 106kg. and above | 4 | 3 | 3 | 10 |
| Total | 13 | 17 | 7 | 37 |

The mean average weight attained at 30 weeks by the women in the study was 97kg.. However, there was quite a wide variation either side of this average. The majority of the women (n21, 57%) came into the lower end of the range weighing between 90 and 99kg. at 30 weeks of pregnancy. At the other end of the range, ten women (27%) weighed 106kg. or more with the highest weight being 130kg.. The remaining six women (16%) came in between these two groups weighing between 100 and 105kg..

I noted in chapter one that a common medical definition of fatness in pregnancy is the attainment of the weight of 90kg. by the 30th week of pregnancy (Kliegman and Gross, 1985). Thus, given that these women all weighed at least this much by the 30th week of pregnancy, it would seem likely that they would all be defined medically as fat. To verify this, I spoke to several midwives and G.P.'s in the Southampton area about their views on what particular weight attained in pregnancy they would consider constituted being 'fat' (or 'overweight' or 'obese'). (Details of who was spoken to and the questions that were asked are contained in chapter two). The reason for doing this was to discover if the 90kg. definition operated in practice or if it was a definition used merely in the medical literature. If it did appear to operate in practice, then the women in my sample would be likely to be viewed medically as fat during pregnancy. This would probably result in their having attention drawn to their weight during their pregnancy by medical personnel which would have some potential impact on how they felt about their weight.

The overwhelming conclusion from discussions with these medical professionals was that there is no particular weight in practice that is viewed specifically as constituting fatness in pregnancy. Rather, it

was felt that whether a woman was considered fat during her pregnancy was a matter of 'professional judgement' which was unquantifiable but which, in general, operated on the basis of appearance. In some ways judging cases on individual appearance can be seen as preferable to using a uniform definition of fatness, given that the weight that is 'normal' for some women may not be 'normal' for others. However, there are some problems with this and these emerged from the discussions with the midwives and G.P.'s.

Although there was a reluctance on the part of the midwives and G.P.'s to define what weight they felt constituted fatness in pregnancy, they did give some rough guides of their views. These reveal the extent to which 'professional judgement' can mask the personal views of medical practitioners regarding weight. In addition, they demonstrate the enormous disparity between the views of individual doctors and midwives. Similar findings have been documented in sociological literature regarding medical practitioners' judgements in general (Macintyre, 1977) and medical views of fatness (Allon, 1975). The medical professionals were asked what weights they felt constituted being both 'overweight' and 'obese'. The terms 'overweight' and 'obese' rather than 'fat' were used here as they are the ones most commonly used by medical professionals. The range given for what constitutes being both overweight and obese according to these medical professionals was immense. Two G.P.'s said that, in general, they would view a woman of average height (approximately 1.65m.) weighing 63kg. or more at the beginning of her pregnancy as overweight. Others felt that this figure should be nearer 80kg.. Similarly, in terms of obesity, two G.P.'s felt

a woman weighing 76kg. at the beginning of her pregnancy would be obese whereas a midwife put this figure far higher at 130kg..

It is obvious that, where a group of professionals can use notions of their professionalism in making judgements about people, rather than set down guidelines, then there is going to be some disparity between definitions of something like fatness. This is not necessarily a bad thing, but there should be an awareness that such professional judgement reflects personal values as well as purely medical ones. For women on the receiving end of such definitions there are problems too. In many cases it means that whether a pregnant woman is viewed medically as fat, and consequently whether she receives any comments or advice about her weight, is dependent not just on her weight but on the personal views (or 'professional judgement') of the particular medical professionals with whom she comes into contact. In terms of whether the women in this research were defined medically as fat during pregnancy, it must be concluded here that while they could be defined as such according to the medical literature on the subject, they were not necessarily all so defined by the individual medical practitioners whom they came into contact with.

As was noted in the preceding chapter, all of the women in this study perceived themselves as fat, to some degree, before their pregnancies commenced. There were changes in levels and areas of satisfaction or dissatisfaction with their weight during pregnancy but in terms of self-perception of themselves as fat there was little change. Indeed, even those women who before pregnancy perceived themselves in a more positive light because they had lost weight viewed themselves as fat during pregnancy. This was because the weight they

had lost before pregnancy, and more besides, was quickly regained during pregnancy. However, while all the women viewed themselves as fat during their pregnancies, this was not necessarily viewed in the negative light that it was in the majority of cases before pregnancy and I will turn to these issues below.

## 4.2 FEELINGS REGARDING WEIGHT

While all the women in this study perceived themselves as fat during their pregnancies, the majority reported marked changes in their feelings about their weight during pregnancy from those held prior to pregnancy: 15 women (41%) reported feeling better about their weight during pregnancy; 13 women (35%) reported feeling worse; and only nine women (24%) reported not feeling any differently about their weight. There are a several reasons why fat women might feel differently about their weight during pregnancy than they do before pregnancy. These relate to several issues: the social image of women during pregnancy; actual weight gained and perceptions of this as 'good' or 'bad'; the extent to which pregnancy is a planned and desired event; and, medical and lay comments and advice about weight and eating during pregnancy. The first two of these emerged as major factors shaping these women's feelings about their weight during pregnancy because the women all identified one of these two factors in discussing their feelings about their weight during pregnancy and noted that they caused, in many cases, a change in their perception of their weight. These two factors, which I have called primary factors, emerged as mutually exclusive. The other factors listed above I have called secondary factors. These factors were mentioned by some of the women, but not all, and were not mutually

exclusive. Furthermore, they were not given the same significance that the primary factors were.

The following table classifies the interviewees according to their feelings about their weight during pregnancy and shows the numbers in each group who attributed the above primary factors as contributing to these feelings.

Table 11

Primary Factors Shaping Interviewees' Feelings About Their Weight

| | Primary Factors | | |
|---|---|---|---|
| | Social Image | Amount | Total |
| Feelings About Weight: | | | |
| Better than before pregnancy | 12 | 3 | 15 |
| Same as before pregnancy | - | 9 | 9 |
| Worse than before pregnancy | - | 13 | 13 |
| Total | 12 | 25 | 37 |

A total of twelve women (32%) reported that the social image of women during pregnancy accounted for their feelings about their weight during pregnancy. In all cases this led to improved feelings about their weight. A total of 25 women (68%) reported that the amount that they weighed accounted for their feelings about their weight during pregnancy. In three cases this led to their feeling better about their weight, in thirteen cases it led to their feeling worse and in nine cases there was no change. I will now go on to discuss these primary factors.

4.2(1) Primary Factors (1): The Social Image Of Pregnancy

In the preceding chapter I noted that most of the women in this study had felt unhappy about their weight before pregnancy and that this unhappiness stemmed from their failure to conform to cultural notions of attractiveness for women. There is a substantial literature noting that the result of the emphasis placed on women's physical appearance in patriarchal societies is that women who fail to conform to notions of attractiveness (such as fat women) are likely to earn the disapproval of themselves and of men and, as a result, to feel alienated from society to some degree (Cline and Spender, 1987; Bovey, 1989). The social image of women in a non-pregnant state identified in the literature and supported by this research, and the impact it has on fat women, can be characterised in the following way:

1. Women are taught that to be socially acceptable they must strive to achieve and retain sexual attractiveness.
2. To achieve sexual attractiveness, women must be slim as one of the tenets of sexual attractiveness is slimness.
3. Fat women are, therefore, not sexually attractive and consequently are, to some degree, socially unacceptable.

It is important now to go on to examine if the social image of women *in pregnancy* is somehow different to the social image of women, as outlined above, at other times. If a social image of pregnant women can be identified that defines women in ways other than in terms of their sexual attractiveness and physical appearance then it is likely that fat women, who feel alienated from society because they do not fit the social image of *women*, might feel less alienated during pregnancy because they can more easily fit the social image of *pregnant women*.

This social image being examined here is distinct from the stereotypes of 'mother' and 'lover' noted in the preceding chapter. These stereotypes apply to individual women and their roles but they do not reflect the social image of women as a group. While stereotypes relating to women's social roles as lovers or mothers exist they do not alter the fact that women in the non-pregnant state, whether they are married or single, mothers or childless, are viewed *socially* in terms of their physical attractiveness. I would argue that this social image of women in terms of physical attractiveness, as outlined above, supersedes all other roles and images of non-pregnant women in society. Evidence of this is the fact that after marriage and childbirth many women are criticised for 'letting themselves go' in terms of personal appearance and parenting and slimming magazines are full of advice regarding the importance of maintaining sexual attractiveness after such events. Thus, for non-pregnant women, whether they are mothers or not, the social image of women is one that defines them in terms of their physical or sexual attractiveness.

Pregnancy as opposed to motherhood may have a different social image. Pregnancy is a time when women's bodies naturally undergo great changes in size and shape. This means that a woman in the latter stages of pregnancy can unmistakably be identified as a soon-to-be mother on the sole basis of her physical appearance. This is a relatively unique situation in the life course of most people. In general people cannot make judgements about other people's social situation strictly on the basis of their bodily appearance. An exception to this is the case of physically handicapped or disabled people, but in the case of able-bodied people, reference usually needs to be made to clothing, facial

expression, words or actions to make more accurate assumptions about people (Goffman, 1971). Women who have been pregnant and become mothers do not carry any strictly *bodily* signs, visible to the rest of society, that they are mothers. This is one of the reasons why they are able to be viewed in terms of their sexual attractiveness as a woman rather than by their role as a mother as has been discussed above. Thus, it is only when women are pregnant and display the visible signs of pregnancy that there exists the potential for an alternative social image to the one outlined above.

I noted in chapter one that there is a varied literature that has noted that women are viewed and treated differently in pregnancy than they are at any other time (Graham, 1976; Charles and Kerr, 1986b; Price, 1988). In summary, the social image of pregnant women identified in the literature can be characterised in the following way:

1. Pregnant women are defined by the fact of their pregnancies rather than by their physical appearance (in terms of attractiveness) and their bodies are viewed as productive rather than sexual.
2. Pregnancy is a condition that has high social status.
3. Pregnant women are viewed as being in need of care and protection and as a consequence are cared for in a way that non-pregnant women are not.

There was some evidence from the research for the existence of this alternative social image of women during pregnancy. A large number of women reported feeling that they were viewed by people they met in social situations primarily as *pregnant* women rather than just as women. This, they felt, meant that they were not judged by others in terms of their physical appearnace relating to their sexual attractiveness.

Additionally, it was also noted by some women that they were viewed in a similar way in their personal relationships. In terms of relationships with partners, one result of this appeared to be a decline in the view of women as sexual partners. It was frequently noted that there was a decline in sexual activity during pregnancy. This was noted to be due in part to a decline in the women's libido but reference was also made to feelings that they were not sexual when pregnant and that their partners did not view them as such. Finally, there was some evidence that the women were also treated differently during pregnancy. This occurred both in the 'public' and 'private' spheres. In the public sphere, several women said that they felt that people paid greater attention to them during pregnancy and that they were treated in a more benevolent manner than at other times. In the private sphere of the home, changes in treatment were manifested in two ways: first, through partners or kin giving the women presents or 'treats' and, secondly, through helping the women, albeit to a limited degree, in order to relieve them of some of their domestic responsibilities. These changes in treatment are symbolic of the social status of pregnancy and the view that women need to be cared for during that time.

There is, then, some evidence from the research for a social image of pregnant women that is different to the social image of non-pregnant women. It is now necessary to go on to examine if this social image of pregnant women had an effect on this group of fat women's experiences regarding their weight during pregnancy. While the social image of pregnancy outlined above contains three elements, it is the definition of pregnant women in terms of their pregnancies rather than their sexual attractiveness and the view of their bodies as productive rather than

sexual that is of greatest importance here. Existing alongside this view of pregnant women is the notion that pregnancy is the one time that it is socially acceptable for women to be fat. This point has been noted in some of the literature on pregnancy (Breen, 1981; Orbach, 1984). Thus, during pregnancy not only are women not judged in terms of their attractiveness but they are actually allowed or even *expected* to be fat. This has obvious benefits for fat women who become pregnant. It would seem likley that, for fat women, pregnancy might be a time when they could feel a degree of social acceptability that is denied to them at other times.

A total of 15 women (40%) felt better about their weight during pregnancy than they had done before pregnancy. Three of these women felt better about their weight because their weight gain had been very low but the majority of these women (n12) reported feeling better about their weight primarily because they felt it was more socially acceptable to be fat in pregnancy. These women made little or no reference to the amount of weight they had put on in talking about their feelings about their weight and size in pregnancy; they identified the chief source of their improved feelings about their weight to be the fact that to be fat was viewed socially as an expected part of being pregnant. The result of these feelings was that they relaxed some of the constraints on their lives that they experienced before pregnancy. Before pregnancy there were three main areas that emerged as problematic for the women in terms of their weight. These were: personal appearance and buying and wearing clothes; taking part in sporting or social activities; and comments from family members and others and a desire to lose weight to please them.

Those women who identified feeling that their weight was more socially acceptable in pregnancy noted that these areas of difficulty before pregnancy declined markedly in importance during pregnancy.

In terms of personal appearance and buying and wearing clothes it was noted that, because fatness is an acceptable part of being pregnant, this was no longer a problematic area of their lives. There are undoubtedly limits on the extent to which fatness is socially acceptable during pregnancy. The social ideal of a pregnant woman's size and shape may not necessarily correspond to the size and shape of the women in this study. Nevertheless, even though these women may not have fulfilled the ideal of how women should look in pregnancy, the greater social acceptability of fatness in pregnancy did result in these women feeling far better about their weight in pregnancy than they had before. The result of these feelings was that this group of women felt that the social prohibition on appropriate clothes for fat women was lifted and they felt able to wear clothes, such as shorts or tee-shirts, that they would not wear in a non-pregnant state. Furthermore, buying clothes became a less problematic activity during pregnancy, again because of the greater social acceptability of fatness.

The experiences of this group of fat women appears to be in sharp contrast to the experiences of average weight women who become pregnant. Research such as that carried out by Oakley (1980) and Macintyre (1981) has noted that women of average weight express considerable dislike for pregnancy's effect on their size and shape (see also Price, 1988). These authors note that average weight women often feel very dissatisfied with their weight during pregnancy because of the connotations fatness has with being unattractive. For fat women,

fatness is a part of their everyday experience and in a way pregnancy makes little difference to them in terms of appearance. The major difference is that their fatness becomes, to some degree, legitimated because it is viewed as a necessary part of pregnancy. Fat women during pregnancy are, then, less likely to feel that they look 'wrong' and one consequence of this is likely to be an easing of feelings of self-consciousness and an easing of self-imposed and societally-imposed restrictions on wearing and buying clothes. The following quotations demonstrate how, for the group of 12 women being focused on in this section, pregnancy legitimated their fatness and also had a positive effect on feelings regarding personal appearance and clothes:

> 'It used to bother me but now, like if I go to the beach, I just put a big tee-shirt on and think: who cares, I'm pregnant and people think: oh that poor pregnant woman rather than anything else'
> (Sandra Crocker).

> 'I feel people can't say to me "Oh she's really fat", people can say "Oh she's pregnant". Rather than when I'm not pregnant, I'm fat, whereas with being pregnant, I'm pregnant. People don't look at you so disgustingly when you're pregnant and wearing something like shorts as they do when you're just vastly overweight'
> (Katie Price).

In addition to the changes in feelings and attitudes relating to their personal appearance noted by this group of women, they also noted that they felt differently about participating in social and sporting activities during pregnancy. During pregnancy, because these women felt that their weight was more socially acceptable, some of them felt more able to participate in activities that they had felt excluded from before pregnancy. The most frequently cited activity that the women reported feeling able to participate in during pregnancy was swimming.

Interestingly, this was the activity that was most often seen as one to be avoided before pregnancy because of the necessity of having to expose one's size and shape. The following quotation was typical of several women's responses:

> 'I've only just started going swimming. I find pregnancy a good excuse. I go there deliberately and I think I'm not worried because I'm pregnant. It sounds daft, I don't know if it's in my mind or if people tend to accept me more because I'm pregnant and big, whereas before they'd sort of, well they wouldn't say anything to me, but you get the feeling they're thinking: look at the size of her. Now I'm pregnant they probably say "Oh doesn't she look wonderful?"'
> (Brenda Gray).

The third area identified above as problematic for the women in terms of their weight before pregnancy was that of comments from partners and others and a desire to lose weight to please them. Comments and advice from partners, kin, friends and also medical professionals did not emerge as a primary factor in shaping the women's feelings about their weight during pregnancy although, along with other factors, it did contribute to such feelings and these will be discussed in detail in the section on secondary factors below. Here it is sufficient to note that for this group of women (n12), comments from partners, kin and friends regarding their weight were few and were not of a critical nature. This is in contrast to the situation before pregnancy when many of the women in the study noted that they regularly received comments from partners regarding their weight. While several of the women noted that their partners wanted them to lose weight, comments relating to this were generally avoided during pregnancy because this was not seen as a time when anything could be done about it. In addition, where comments were made these were not taken as

seriously by the women as they might have been before pregnancy. Again, the fact that women are expected to be fat during pregnancy probably contributes both to the reduction in the number of comments and the way such comments are received by the women. The following quotation illustrates these points:

> 'He often says things to me but he's stopped at the moment because he realises being pregnant I can't diet. But he'd like me to lose some weight'
> (Jackie Johnston).

This group of women, then, felt more satisfied with their weight during pregnancy than they had done before pregnancy. The areas identified as problematic regarding their weight before pregnancy were all viewed as much less so during pregnancy. The factors that the women identified as leading them to feel better about their weight related to the notion that it is socially acceptable for women to be fat during pregnancy. This, I have argued, relates to the social image of pregnancy that I have outlined above, that is, that during pregnancy the focus is on this rather than on their sexual attractiveness and during this time their bodies are viewed as productive rather than sexual.

4.2(ii) Primary Factors (2): Actual Weight Gain

All of the remaining women in the study (n25) noted that their feelings regarding their weight in pregnancy emanated from the actual amount that they weighed and their perceptions of this as 'good' or 'bad'. While many of the women in this group were aware of feeling that it was more socially acceptable to be fat in pregnancy, this was not a factor shaping their feelings regarding their weight in pregnancy. It was noted by several women that allowing themselves to feel satisfied about their weight during pregnancy, because to be fat was socially

acceptable, could result in greater weight gain that would be hard to lose after pregnancy. In addition, these women were aware that what might be socially acceptable in pregnancy would be once again socially unacceptable after pregnancy.

As Table 11 shows, of the 25 women in this group, three women reported feeling better about their weight during pregnancy, nine women reported feeling the same and 13 women reported feeling worse. The concentration on the actual amount that they weighed in determining how they felt about their weight during pregnancy is a predictable response for fat women to have. Fatness is defined not just by appearance but also by the actual quantifiable amount and the focus by the medical profession and the media on 'ideal' weights contributes to this. Thus for most women, becoming slim is not merely a matter of looking slim but reaching a particular weight that is equated with slimness. Given this focus, it is probably unsurprising that these women identified their feelings about their weight in pregnancy to be related to the amount of weight that they gained and their interpretation of this as 'good' or 'bad'.

The women in this group who felt better or the same about their weight during pregnancy (n12) reported that they did so because their weight gain had been what they perceived as 'good'. Conversely, the women in this group who felt worse about their weight during pregnancy (n13) did so because their weight gain had been what they perceived as 'bad'. These notions of 'good' or 'bad' did not appear, in general, to correspond solely to current medical opinion on acceptable weight gains in pregnancy. The information regarding acceptable weight gain obtained from the medical literature given to the women at the ante-natal

clinics, seemed only to *contribute* to their own personal targets and expectations regarding weight gain. This can be seen by comparing the average or acceptable weight gain recommended in the medical literature with the weight gains that the women noted as 'good' or 'bad'. The pregnancy weight gain recommended in the literature given to the women at the ante-natal clinic was around 12.5kg. during an entire pregnancy (Health Education Authority, 1984; The Royal College of Midwives, 1987). Yet some women with weight gains well below this level at 30 weeks felt that their weight gain was excessive whereas others with weight gains above this level did not.

It is useful to note here the range of weight changes for this group of 25 women. These are set out in Table 13 for the whole sample on the section discussing the women's experiences regarding weight and eating below. In the group who reported feeling better about their weight during pregnancy, pregnancy weight changes ranged from weight loss in the case of one woman, to weight gains of up to 11kg. at around 30 weeks. In the group who felt the same about their weight during pregnancy, weight gains ranged from 2 to 30kg. and in the group who felt worse about their weight during pregnancy weight gains ranged from 6 to 33kg.. In this latter group nine of the women weighed between 6 and 15 kg. more, and the remaining four women weighed between 22 and 33kg. more. Thus, it seemed that it was not necessarily the amount that was gained in relation to medical expectations of average weight gain in pregnancy that led to the women feeling differently about their weight, although of course such expectations may have had some impact. Rather, it seemed that personal views of acceptable and unacceptable levels of weight gain appeared to be more important to this group of women. Such

personal views seemed to be dependent on the women's feelings and experiences regarding their weight before pregnancy. For example, some women who had made great efforts to lose weight before pregnancy found almost any weight gain disturbing. Others who expected larger than average weight gains because of their propensity to fatness were surprised and pleased to gain less than they had anticipated. The following quotations show how the women's perceptions of a 'good' or 'bad' level of weight gain affected how they felt about their weight in pregnancy. The first two quotations are from women who reported feeling better about their weight during pregnancy and the latter two from women who reported feeling worse:

> 'I'm really pleased with my weight because I expected to balloon out and be absolutely gi-normous and I had all these maternity dresses made for me and they're all miles too big. ... It never worried me that I wasn't gaining a lot of weight, even though the hospital went on about it, because I had a lot of weight there before I started. I knew that there was so much extra there'
> (Carol Smith, weight gain at 30 weeks: 11kg.).
>
> 'I'm really pleased that I haven't put on very much weight. Mr. James [hospital consultant] keeps on about my weight and that's upset me but *I'm* pleased about it because I did expect to put on more, like I did last time [in previous pregnancy]'
> (Fiona Tindall, weight gain at 30 weeks: 7kg.).
>
> 'I still don't like my weight and I'd rather have not put on any weight at all. I mean the baby, no matter how hard it tried there was no way that it was going to starve to death inside my body, there's just too much of everything there for it. ... I know I didn't need to put on any weight, they [the hospital] didn't tell me but I knew it would be okay if I could have managed it - it was just logic I think. ... I mean, I'm fat enough as it is and I thought if I put on a lot then I'm going to be even worse when I've had the baby'
> (Susan Hartwell, weight gain at 30 weeks: 30kg.).
>
> 'I haven't put on that much but it feels such a lot. I can't wait to get rid of it. I really could have done with not putting on any weight or losing weight'
> (Rachel Hardwick, weight gain at 30 weeks: 8kg.).

Thus for a large number of women, their feelings about their weight during pregnancy were determined by the actual amount that they weighed. While notions of fatness being more socially acceptable in pregnancy were acknowledged by these women, these did not affect their overall feelings about their weight. Weight changes during pregnancy were viewed as 'good' or 'bad' in accordance with the women's notions of acceptable weight gain *for them*. Acceptable levels of weight gain according to medical criteria were noted by the women but these appeared to be secondary in shaping the women's feelings about their weight. Personal levels of acceptable and expected weight gain in pregnancy seemed to be created by the women as a result of their past experiences and feelings regarding their weight.

I noted above that the social image of pregnancy and personal notions of 'good' and 'bad' levels of weight changes were primary factors in *shaping* this group of fat women's feelings regarding their weight in pregnancy. Other factors emerged as important, although to a lesser degree, in *contributing* to women's feelings regarding their weight in pregnancy. These factors I have called secondary factors. The following table shows the numbers of women in each group who experienced these secondary factors. As can be seen from the table, these factors were not mutually exclusive as the primary factors were and some women reported experiencing more than one factor. A total of 29 women (78%) reported receiving medical comments and/or advice during their pregnancy. Twenty-four women (65%) received lay comments or advice and 23 women (62%) reported that they were not dissatisfied at being pregnant. Each of these factors emerged as important in

contributing to women's feelings about their weight and I will now go on to discuss these secondary factors.

Table 12

Secondary Factors Contributing To Interviewees' Feelings About Their Weight

| | Secondary Factors | | |
|---|---|---|---|
| | Medical Comments/ Advice | Lay Comments/ Advice | Pregnancy Desired |
| Feelings About Weight: | | | |
| Better Than Before Pregnancy (n15) | 11 | 9 | 10 |
| Same As Before Pregnancy (n9) | 7 | 5 | 6 |
| Worse Than Before Pregnancy (n13) | 11 | 10 | 7 |
| Total | 29 | 24 | 23 |

4.2(iii) Secondary Factors (1): Medical Advice

In chapter one I noted that there is a wide medical literature regarding maternal weight and pregnancy and that there is some consensus in this literature that fatness in pregnancy constitutes some health risks for both mother and baby (Garbaciak et al, 1985; Kliegman and Gross, 1985). The medical interest in maternal weight has found its way into the ante-natal literature that is given to all pregnant women at ante-natal clinics. All the ante-natal literature that is given to women contains a considerable amount of information and advice regarding

weight, weight gain and diet. Thus, it seems that weight and diet during pregnancy are central concerns of the medical professionals involved in pregnancy.

Given this wide medical interest in weight during pregnancy one would expect that this group of women would have been likely to receive some advice regarding weight gain or diet during pregnancy. Surprisingly, advice was, in general, not as common as might be expected. It is necessary here to make a distinction between 'advice' and 'comments'. 'Advice' I have defined as being when medical professionals gave women particular instructions regarding how much weight they should aim to gain or the sort of foods they should eat or avoid. 'Comments', on the other hand, I have defined as being when medical professionals made reference to women's weight or diet, often in a disaproving way, but where no instructions regarding what they should do about it were made. Thus, 'comments' differ to 'advice' in that they contain no instructions and are therefore presumably not made with the intention of trying to help the women to restrict their weight gain or change their diet. 'Comments' appeared to be casual remarks or observations about women's size or shape and seemed to occur more as a result of a medical professional thinking aloud rather than anything else. Given this distinction between advice and comments and the medical interest in restricting weight gain in pregnancy for fat women, the likelihood would seem to be that advice rather than just comments would be given to this group of fat women. Surprisingly, however, only 20 women (54%) received advice regarding weight and diet during their pregnancy. The content and reception of advice will be discussed in greater detail below. First I will concentrate on the comments that

some women received from the medical professionals with whom they came into contact during their pregnancies.

A total of nine women (24%) received only comments from medical professionals during pregnancy. A greater number also received some comments regarding their weight or eating during pregnancy but this was in conjunction with advice and so they have been excluded from this group. Comments were generally remarks or observations made about a woman's weight. Often such comments were received as being derogatory or insulting by the women. However, not all women who had comments made to them about their weight received these comments as insulting. Some women appeared unconcerned by such comments and obviously a reaction to comments depends on the individual woman receiving the comment as well as the sort of comment that was made and who made it. The following quotations are examples of the sorts of comments that were made and the responses that the women had to them. In the first example, the woman responded negatively to the comments and in the second example the woman was relatively unconcerned by the comments made to her:

> 'The midwife said "You're terribly overweight". ... and I came out crying and my boyfriend wondered what was wrong. I thought that was a really horrible thing to say to me' (Jenny Harris).

> 'The only thing they say to me now and when I was pregnant before is, when they feel my stomach they say "Oh well the baby's well-protected anyway". Both my doctor and my consultant have said that. ... It doesn't bother me, not at all' (Katie Price).

These quotations illustrate the impact that comments made casually by medical professionals can have. For those women who responded negatively, such comments were important in terms of contributing to their feelings about their weight during pregnancy. Those women who

felt insulted by such comments were likely to end up feeling more dissatisfied about their weight during pregnancy than they might otherwise have done.

Of the 20 women (54%) who received advice, as opposed to comments, regarding weight and eating during pregnancy, 13 received advice that was unsolicited. The remaining seven women in this group *sought* advice from medical professionals. Here I will focus on those women who received unsolicited advice. The number of women who received advice from medical professionals that was not sought (n13, 35%) is surprisingly low given the prominence given to fatness in pregnancy in both the medical and ante-natal literature. There are probably a number of reasons why these women received advice during pregnancy and others did not. Five women in this group had large weight gains ranging from 22 to 33kg. and some of these women, as well as others in this group, had other specific medical or social problems. Such problems were, for example, having a previous history of repeated miscarriage or being a young single parent living on state benefits in poor housing. Only five women received advice for no apparent medical or social reason. These women received advice from their G.P.'s rather than other medical professionals and they noted that their G.P.'s had a 'thing' about weight. I have already noted at the beginning of this chapter that medical definitions of what constitutes fatness in pregnancy is largely dependent on doctors' individual views. Thus, the finding that some women received advice from their G.P.'s whereas others of a comparable weight did not is unsurprising. It does seem to be usual then, for this group of fat women at least, that advice is not routinely given except

in special cases or where individual doctors view low weight gain as important.

Being given advice often had some impact on the women's feelings about their weight in much the same way as comments regarding women's weight did. Again, some women were offended at being given advice about their weight because they felt that medical professionals were implying that they were not aware of their weight problem or not trying to do anything about it - a situation that was far from the truth. Others found advice distinctly unhelpful and felt that their excessive weight gain in pregnancy was directly attributable to the advice that they had received. Some women, however, were not offended by the advice that they received and, on the contrary, found it very helpful and tried to follow it as far as possible. Whether the impact of advice was negative or not appeared to be mediated by a number of factors. Amongst these, the type of advice that was given, the person who gave the advice, the woman's perception of her weight and the significance attached by her to medical advice were important. For this group of fat women unsolicited advice-giving was a relatively unusual occurrence and perhaps because of this it seemed to have less of an impact on the women's feelings about their weight than might be expected. Furthermore, advice from medical professionals was not constantly given at every ante-natal visit and often was only given once at a first visit. This may have contributed to its having less of an impact in determing feelings about weight. While some women reported that medical advice did have a negative impact on their feelings about their weight, this did not seem to be a major factor in determining these feelings. Rather, advice that was viewed by

the women in this negative way seemed to contribute to already existing feelings about their weight.

I have noted above that unsolicited advice was reported to be a rare occurrence for this group of fat women. In order to examine further whether this was actually likely to be so or was merely interpreted as such by the women I interviewed, I also interviewed various medical professionals involved in ante-natal care to discover their views and practices on this topic (details of who was spoken to and the questions that were asked are contained in chapter two). The main reason for these interviews was to discover whether advice-giving to the fat women in my study was likely to have been as infrequent as it was reported. From the various interviews with medical professionals it emerged that this paucity of advice that the women reported was probably an accurate representation of what occurred. The medical professionals to whom I spoke seemed to operate with a stereotype of fat women that meant giving advice to them during pregnancy was viewed as pointless. Repeatedly, fat women were referred to as being 'a lost cause' or 'beyond help' and their attitude was characterised as being one of 'not caring less'. This following comment from a midwife was typical:

> 'It's the ones that are really obese that are the ones. Well, they're a lost cause really. We say to them, "We don't expect you to put on as much weight as others", but then you see them in the precinct with their bag of chips. They just don't care'.

Operating alongside this stereotype of fat women were two further notions that militated against the giving of advice by health professionals. First, there was the notion that being fat in pregnancy does not pose a significant health risk to the baby. While some medical

professionals noted that there were long-term health risks to the women in being fat, they noted that their chief concern and responsibility during pregnancy was to the unborn child. Thus, giving advice during pregnancy, on this count, was seen as unnecessary. Secondly, there was a notion of individual responsibility for health. Several of the medical professionals that I spoke to noted that it was up to the women, rather than the medical profession, to do something about their weight and the phrase 'you can't help those who won't help themselves' was common. All these factors militate against the giving of advice to fat pregnant women and it seems likely, therefore, that the women in this study did receive the minimal advice that they reported. As was noted above, this lack of advice may explain why it was not a major factor in determining the women's feelings about their weight during pregnancy.

I noted above that some women sought advice about their weight or eating during pregnancy. Most of these women reported feeling that they would not have received any advice if they had not asked for it first. A total of seven women (19%) said that they sought advice from the various medical profesionals with whom they came into contact during pregnancy. The following quotation regarding advice seeking was typical:

> 'He [G.P.] never said anything to me but I said to him, like asking about calories, like how many should I have through the day so that I didn't have any less than I should because I didn't want to put on too much weight' (Jackie Johnston).

For this group of women, then, because advice was sought rather than given unsolicited it had little impact on their feelings about their weight. The extent to which advice was followed, for both groups of

women, and the impact this had on diet will be discussed below in the section on eating during pregnancy.

4.2 (iv) Secondary Factors (2): Lay Advice

The majority of the women (n24, 65%) received lay advice or comments about their weight or eating during pregnancy. However, for most of these women, the comments or advice that they received were related solely to diet and were unconnected to weight or weight gain. Such comments or advice had no impact on how the women felt about their weight although they may have had an impact on the women's diets and this will be discussed below. Only nine of the women (24%) received comments or advice specifically about their weight. In all these cases the comments or advice were given either by the women's mothers and/or by their partners. Comments or advice from the women's mothers tended to be either approval or disapproval at weight gain or advice regarding how difficult excess weight would be to lose. In general, comments or advice from mothers was constructive and helpful. Partners generally made comments rather than gave advice. These comments tended to focus on the women's personal appearance and generally related to observations on weight gain. The following quotations illustrate the sorts of comments or advice given by both mothers and partners:

> 'My mum is interested in what [weight] I put on and pleased that I haven't put on a lot, and the encouragement is there not to'
> (Gill Russell).

> 'She [mother] actually turned round and said to me yesterday after I'd come back from the hospital and she said "Have you put much [weight] on?" and I said "Oh, I've put on so much" and she said "Yeah, you can see you've put a little bit on", she said, "but so far, you know, it's alright, but you don't want to put too much on"'
> (Michelle Pointer).

'My husband keeps saying that I'm getting porkier and porkier'
(Julie Woodford).

'My husband sits there and tuts when I tell him how much weight I've put on'
(Claire Whitcher).

Thus, for the women in this study, lay comments and advice about their weight during pregnancy were uncommon. This situation is in contrast to that of before pregnancy, and the social image of pregnancy that views fatness as an expected part of pregnancy probably accounts for both the low level of advice or comments and the minimal effect that these had on the women. Where advice or comments did occur they tended to be comprised of approval or disapproval at weight gain. Such approval may have led to women feeling better about their weight during pregnancy while disapproval may have had the opposite effect. However, it was noted that where disapproval occurred this tended to be more muted during pregnancy and to have less of an effect on the women. Thus, because of this and the small numbers involved it seems that comments and advice were not a major factor in determining this group of fat women's feelings about their weight during pregnancy.

4.2(v) Secondary Factors (3): The Desirability of Pregnancy

There is a considerable literature from the field of psychology noting that the extent to which women feel content with their pregnancies is linked to the extent to which they accept their femininity. (For a discussion of these psychological approaches see Oakley, 1980; Boulton, 1983.) It is noted in some of this literature that dissatisfaction with pregnancy, resulting from maladjustment to femininity, can manifest itself in, among other ways, a negative

attitude to pregnancy size. Sociologists have argued that dissatisfaction with pregnancy arises not solely from psychological problems but from both the physical and social situations and consequences of pregnancy. There is no sociological research linking dissatisfactions resulting from the physical and social consequences of pregnancy with a negative attitude to pregnancy size. However, such a connection seems a possibility. For the purposes of this discussion it is not necessary to analyse whether the basis for some of the women's dissatisfaction with their pregnancies was social or psychological. The important point to note here is that such dissatisfactions, where they exist, might result in women having a negative attitude to one of the manifestations of pregnancy, that is, their changed size.

Sixteen of the women in the study (43%) reported that they were pleased upon having their pregnancies confirmed, or soon after. Not all these women had planned their pregnancies but nevertheless none of this group reported feeling dissatisfied about being pregnant. A further group of women were particularly *happy*, rather than just pleased, to be pregnant. This group consisted of seven women (19%). The women in this group had experienced either a long period of infertility and had been attending an infertility clinic, or repeated miscarriages or stillbirths. For these women, then, the discovery that they were pregnant was experienced with some elation, although this may have been tinged with some anxiety as to the outcome of the pregnancy. In contrast to this group of women, another group of women were particularly *unhappy* to be pregnant. A total of 14 women (38%) came into this group. All the women in this group had not planned their pregnancies. They were either young, single women or women who became

pregnant after feeling that they had completed their families or too soon after a previous pregnancy. For these women, the discovery that they were pregnant was experienced with unhappiness, or even, in some cases, despair.

It is a possibility that the group of women who felt very happy at having become pregnant might as a consequence feel satisfied and content about putting on weight and being fat in pregnancy. A change in size and shape is one way that pregnant women can publicly display that they are pregnant. Conversely, women who felt unhappy about becoming pregnant might have the opposite experience. These women, because they did not wish to be pregnant, might feel unhappy about their change in size and shape during pregnancy as it is a demonstration of what is to them an undesired state.

There was some limited evidence that those women who particularly desired their pregnancies felt better about their weight during pregnancy than those women who did not wish to be pregnant. The following quotations help to illustrate how desirability of pregnancy seemed to affect feelings about increased size. The first is from a woman who had been attending an infertility clinic for eight years and was expecting her first child at the age of 34. She was very happy to be pregnant and enjoying her pregnancy:

> 'I haven't really thought about my weight since I've been pregnant. I think because we've spent so long waiting for this baby, I think more about the actual baby than I do about my weight. Obviously afterwards is going to be a problem but I can't think about that now. I suppose you do tend to think: oh well, your weight doesn't matter quite so much when you're pregnant because it's part of being pregnant and that's what we've wanted for such a long time' (Margaret Marshall)

The second quotation is from a young 20 year old woman who had become pregnant as the result of a relationship with a married man with whom she was no longer in contact. The pregnancy was unplanned and had caused a number of changes in her life that she did not want, such as having to leave work and to move back home with her parents:

> 'I feel awful about my weight. It's like, all my clothes, because I've had to go out and buy bigger clothes, bigger jumpers and bigger trousers and I'm fed up with it. I just want to get back into what I used to wear before. ... I was shocked and embarrassed when I first found out I was pregnant. I didn't go to my doctor's until I was six months although I knew from two months. I think when I was about six months or before that I didn't mind going out, but like now, I run quickly down to the shop and that's it. I don't want anyone to see me really'
> (Anne Walker).

These two examples illustrate how women's feelings about their pregnancy can have an impact on their feelings about their weight. It seems possible that the women who wanted to be pregnant felt better about their weight during this time, partly as a result of the social image of pregnancy that equates pregnancy with fatness and partly because they saw this as a demonstration to the outside world of, what was to them, a desired state. Conversely, the opposite was perhaps true for those women who did not want to be pregnant. However, while the desirability of pregnancy appeared to have some impact on the women's feelings about their weight, this did not seem to be a major factor in determining their experience. Again, the proportion affected was relatively small. Furthermore, feelings regarding the desirability of pregnancy were subject to change during the course of the pregnancy. Some women who expressed regret at becoming pregnant came to a position of acceptance during later pregnancy and, in some cases, even happiness

at the prospect of a new baby. Conversely, women who had desperately wanted to be pregnant expressed anxiety in later pregnancy at the prospect of the changes that a baby would bring into their lives. It is not possible, then, to quantify the impact of the desirability of pregnancy on these women's feelings about their weight. However, as I have argued, it seems likely that such impact was of secondary importance.

In summary, then, many of the fat women in this study found that their feelings about their weight during pregnancy were subject to some change: some women felt more satisfied with their weight and others felt less satisfied with their weight during pregnancy. Two major factors emerged as explanations for these changes: the social image of women during pregnancy which legitimates, to some extent, fatness; and, personal perceptions of weight gain as 'good' or 'bad'. One of these two factors was identified by all the women as most important in shaping their feelings about their weight during pregnancy and, in some cases, leading to changed feelings. These factors, then, were primary in shaping the women's feelings about their weight during pregnancy. Other factors emerged as important, although much less so, and these I have called secondary factors. These secondary factors affected some women, although not all, and were not given the same importance by the women as the primary factors. Therefore they contributed to rather than shaped women's feelings about their weight during pregnancy. These secondary factors were: medical and lay comments and advice about weight and eating during pregnancy; and the desirability of pregnancy.

The discussion so far has concentrated on the women's *feelings* about their weight during pregnancy. I would now like to go on to

discuss the women's *experiences* regarding their weight and eating during pregnancy. Central to this discussion will be the identification of the factors that led to differential levels of weight gain amongst this group of fat women. These factors will be identified from those that the women perceived as important and from those that emerge from the data as important. Again, as with the areas identified in the previous chapter, these are not intended to be mutually exclusive. On the contrary, in the majority of cases it seemed that several factors operating together could account for particular experiences of weight gain. The majority of the factors associated with differential levels of weight gain are connected to eating. Thus, in addition to the discussion of differential levels of weight gain I will also be examining the changes that took place in the women's eating practices from those of before pregnancy that were identified in the previous chapter. I will discuss how far such changes occurred as a result of pregnancy and whether such changes were coped with in a specific way by these women because they were fat.

## 4.3 EXPERIENCES REGARDING WEIGHT AND EATING

The following table divides the women into three groups according to their feelings about their weight and sets out the weight changes experienced by the three groups of women at 30 weeks of pregnancy. As can be seen from the table, the women in the study reached a variable level of weight gain by the 30th week of pregnancy. As I have noted above, the average weight gain throughout an entire pregnancy is about 12.5kg. (see Walker et al, 1976). It is noted that by the 30th week of pregnancy an average weight gain would be about 8kg.. Many of the women

in the study did achieve a weight gain close to this average at the 30 week point. A total of 20 women (54%) weighed between 6kg. and 12kg. more at 30 weeks. However, a significant number came outside this average range of weights. A total of nine women (24%) weighed under this point at 30 weeks. Their pregnancy weights ranged from weight loss (in two cases) to weight gains of up to 5kg. The remaining eight women (22%) weighed above this average with weight gains ranging from 13 to 33kg..

Table 13

Weight Changes Of The Interviewees At 30 Weeks Pregnant

| | Weight Changes | | | |
|---|---|---|---|---|
| | Weight loss- Gain up to 5kg. | Weight Gain 6-12kg | Weight Gain 13kg. or more | Total |
| Feelings About Weight: | | | | |
| Better Than Before Pregnancy | 6 | 8 | 1 | 15 |
| Same As Before Pregnancy | 3 | 4 | 2 | 9 |
| Worse Than Before Pregnancy | - | 8 | 5 | 13 |
| Total | 9 | 20 | 8 | 37 |

The actual level of weight gain (or loss) achieved at 30 weeks is not intended to be taken as being of especial significance here. These data give only a snapshot picture of the women's weight gain during pregnancy and it is not intended that they should do more than that.

However, these weights do serve as an illustration of the differential levels of weight gain that the women experienced during pregnancy and thus allow an examination of why different levels of weight gain might occur. It is the factors that were seen as contributing to particular levels of weight gain that I will now go on to discuss. These factors come under five headings: first, physiological; secondly, pregnancy as a life event; thirdly, the physical effects of pregnancy; fourthly, changes in the practical and ideological organisation of food and eating; and fifthly, advice. As with the previous chapter, only the first of these factors was largely unrelated to eating. The other factors were all related to eating in some way and the discussion, therefore, illustrates the changes that took place in eating practices as a result of pregnancy for this group of fat women.

4.3(i) Physiological Factors

I noted in chapter one that some of the clinical literature identifies physiological problems, such as fluid retention, as one explanation of large weight gains in pregnancy (Iffy and Kaminetzky, 1981). Such explanations are largely unrelated to consumption although overweight women may be more prone to fluid retention than slimmer women. A number of the women in this study who had what they felt were high weight gains acknowledged that this might, in part, be due to physiological factors. Several women noted that they felt that they must be 'carrying a lot of water' or 'carrying a big baby' because they could not account for their high weight gains solely in terms of consumption patterns. However, in no cases did women account for their weight gain *solely* in terms of physiological factors. Women who acknowledged physiological factors in what they felt to be high weight

gains also acknowledged that their diet was a major contributory factor in this. Furthermore, they noted that restricting their diet would probably have led to a smaller weight gain. Thus, consumption patterns were seen as a major cause of high weight gains which, in some cases, acted in conjunction with physiological factors such as fluid retention. A total of ten women (27%) acknowledged physiological factors as having some impact on their weight gain. The following quotation regarding this was typical:

> 'I've put on about 4½ stone [29kg.] so I'm not really happy with it but it's one of those things. ... I suppose I have eaten a lot but I think I'm also carrying a lot of fluid'
> (Rebecca Young).

It is probably unsurprising that fat women are more likely to attribute large weight gains in pregnancy to consumption patterns rather than to physiological factors that are out of their control. These women's past experiences are likely to have taught them that their size is largely attributable to what they eat. In addition, the focus on weight gain in ante-natal literature is invariably related to diet and this is likely to contribute to this view. All the other factors identified as leading to particular levels of weight gain relate to eating in some way and it is these that I will go on to discuss.

4.3(ii) Pregnancy As A Life Event

I discussed at length in the preceding chapter the topic of stressful life events and their link with eating or overeating. It is, therefore, not necessary to reiterate that discussion in full here but I will summarise the main points that emerged in order to see the extent to which these relate to pregnancy. I noted that there are three levels

of stressful life events outlined in the literature: the first relates to disturbing or traumatic life events such as serious illness, bereavement or divorce; the second relates to less dramatic or disturbing life events but ones that neverthless bring about change; and the third relates to the stresses and strains inherent in everyday life. In the face of any of these levels of stress some people may turn to food and overeat in order to help them to cope. I noted that the majority of women in this study reported that they used food to help them cope with stress to some degree.

Pregnancy has been identified in some literature as being an event leading to various degrees of stress. Some writers have identified pregnancy and childbirth, particularly a first pregnancy, as a major disturbing or traumatic stressful life event (Oakley, 1980). Other writers have identified it as a less severe life event but one that nevertheless results in great changes in women's lives that may lead to the experience of stress (Graham, 1977; Price, 1988). Pregnancy, especially first pregnancy, undoubtedly brings about great changes in women's lives which are likely to be experienced as stressful to some degree. However, the experience of pregnancy as stressful is not necessarily confined to first pregnancy only. Indeed, some writers have argued that a second or subsequent pregnancy can be equally if not more stressful than a first one (Graham, 1977; Breen, 1981). Whether pregnancy is experienced as a major stressful life event or as a less severe event resulting in everyday stresses is, I would suggest, dependent on a number of factors relating to an individual woman's social situation.

For some of the women in this study I would suggest that pregnancy was a major stressful life event. For those whose pregnancies were unplanned and undesired to a great degree the discovery that they were pregnant was met with despair. The experience of pregnancy for them was quite traumatic, especially in the early stages. This group of women have been discussed above in the section on the desirability of pregnancy. A total of 14 women (38%) come into the category of being particularly distressed at discovering their pregnancy and appeared to experience pregnancy, at least initially, as a traumatic event. The responses that these women made when asked how they felt when they first found out that they were pregnant illustrate this:

> 'I was totally shocked. I thought: Oh God, why me?'
> (Rosemary Kemish).
>
> 'I felt devastated. It was a big mistake. I was just getting ready for this September when James [her son] goes to school. I was going to get, well, start living again really, but I can't now'.
> (Jackie Johnston).

It seems clear, then, that some women in this study experienced pregnancy as a particularly distressing life event. There is no *direct* evidence that these women responded to this stress by turning to food but the data obtained from the interviews do indicate that this probably occurred for some of the women in this group. The women in this group who were least advantaged in terms of material and social support all had high weight gains which indicates that they may have been turning to food for comfort in the absence of other support. Five of the 14 women in this group had high (that is, over 12kgs. at 30 weeks) weight gains. Three out of these five women were young, single, working-class women experiencing a first pregnancy while still living in the parental home.

A further woman in this group, although married, was experiencing her second pregnancy at the age of 17. The women who had intermediate (n3) or low (n6) weight gains were more advantaged both materially and in terms of social support. Three of these were young, single women experiencing a first pregnancy while living with their parents but they were of middle-class background and their parents were supportive virtually from the outset of the pregnancy. The other women in this group all had partners who were reported as being happy about the pregnancy. This indicates that these women experienced some level of support from their partners and, furthermore, the social norm of parenthood within families would be likely to make the adjustment to an unplanned pregnancy somewhat easier than for those without stable partners. The benefits that eating can bring in times of stress may mean that when pregnancy is a traumatic experience and when material and social support is low the likelihood of turning to food is quite high. This is perhaps all the more so for fat women, the majority of whom in this sample reported turning to food in times of stress.

For other women in the study, pregnancy was not a major stressful life event but nevertheless was an experience that brought about changes in their lives and these were often viewed as stressful. For women expecting their first baby, leaving work and spending long hours at home was a difficult adjustment to make. For those expecting a second or subsequent baby, coping with existing children and a pregnancy often led to tiredness and irritability. Furthermore, becoming 'a patient' and the experience of regular clinic visits and medical examinations was frequently viewed as stressful. The result of these and other changes brought about by pregnancy led to many of the women feeling bored with

being at home and anxious about their change in circumstances. In addition, they expressed anxiety about childbirth, about their baby's health and development, and about coping with a new baby and motherhood. Such anxieties are not uncommon among expectant mothers and these have been well reported in the literature (see Oakley, 1980; Price, 1988). From the evidence of this research as well as existing literature it seems that pregnancy is an inherently stressful experience. This seems to be true, although for different reasons, for first as well as for second or subsequent pregnancies.

There was some evidence from the interviews that the stress associated with the changes brought about as a result of pregnancy were responded to in some cases by women turning to food. Spending long periods at home, often on their own, with open access to food and with little to do except prepare and think about the coming baby made the use or abuse of food a distinct possibility. This is all the more so for this group of women, the majority of whom (n30, 81%) reported that they ate when they were bored, lonely or fed-up. The following quotation illustrates how women's confinement to the domestic sphere can lead them to eat as a result of boredom and anxieties about their pregnancy:

> 'I hate being at home. I'd rather be working. ... Sometimes I go and have a pick of what's in the fridge, not all the time, usually when I get a bit cheesed off which I do when I'm at home. I get fed-up and then I start worrying about having the baby and the things that they say to you at the hospital and that's when I go and pick at something'
> (Julie Woodford).

The experience of pregnancy as either a major stressful life event or an event that is stressful because it brings about significant changes, did appear to have some impact on these women's experiences

regarding their weight during pregnancy. It seemed that some of the women in this study responded to the various levels of stress brought about by pregnancy by turning to food for comfort and support. Such a response was probably more likely for a group of fat women such as these, given the widely-reported incidence of comfort-eating among such groups and the self-reporting of such behaviour by these women before pregnancy. It is probable that this sort of response would be most likely to occur when material and social support are low although insufficient information was obtained to substantiate this premise fully.

4.3(iii) The Physical Effects Of Pregnancy On Diet

Much of the sociological literature on pregnancy notes that there are a number of physical side-effects associated with pregnancy and that these often have an impact on diet. The most common side-effect associated with early pregnancy is that of nausea and/or vomiting, indigestion and heartburn (Oakley, 1980; Macintyre, 1981). Macintyre (1981) noted that the experience of these two symptoms often had an effect on pregnant women's food consumption. She found that women experiencing such symptoms ate particular foods or ate at particular times of the day in order either to relieve the symptoms or to keep symptoms at bay.

The majority of the women (n28, 76%) reported experiencing symptoms of nausea and indigestion to some degree. The symptoms most commonly experienced were nausea and/or vomiting (in 21 cases) but some women experienced this in conjunction with indigestion and/or heartburn (in six cases). Only one woman experienced indigestion but not nausea. In all cases the experience of these symptoms had some effect on food

consumption although this obviously varied according to the severity and duration of the symptoms.

Four patterns of changed eating behaviour could be identified as occuring as a result of the physical effects of pregnancy. The first changed type of eating behaviour was that some women ate less throughout their pregnancies because they found that this relieved their physical symptoms. The result of this decrease in food intake was that they did not gain as much weight as, in many cases, they had anticipated and several women expressed pleasure at this outcome. The second type of changed eating behaviour was that some women changed the types of food that they were eating in order to relieve the symptoms of nausea and/or indigestion. These women did not necessarily eat less but rather ate *differently*. The extent to which this resulted in a less than anticipated weight gain and consequent pleasure or displeasure depended on the sorts of foods that they ate. The third pattern of changed eating behaviour was that some women ate less when they were first pregnant as a result of feelings of nausea and/or vomiting which inhibited food intake but once the feelings of nausea had passed in later pregnancy they ate much more than they did normally. Several of the women in this group noted that they felt ravenously hungry and felt that they were 'making up' for the time in early pregnancy when they could not eat. Many of these women put on more weight than they had anticipated, especially given the fact that their food intake had declined markedly in early pregnancy, and some were disappointed at what they saw as their high weight gains. The fourth type of changed eating behaviour was that some women ate more right from the beginning of pregnancy as a way of relieving their symptoms. Usually this occurred

as a result of nausea and some women found that constant eating brought some relief from this symptom. The majority of women in this group were unhappy about the weight that they had gained as a result of their eating but felt unable to do anything about it. The following quotations illustrate each of these four types of changed eating behaviour:

> 'I haven't put that much weight on because I've felt quite sick, especially to start with, so I haven't wanted to eat that much and that's pleased me quite a bit'
> (Gill Russell).

> 'Yesterday I had Angel Cake and milk and that's all I had all day. But that's what happens some days. Like at the moment I'm living on digestive biscuits and milk because that's the only things that help my indigestion'
> (Fiona Tindall).

> 'I lost about a stone at the beginning of my pregnancy. I had severe sickness and I was in bed for two weeks and not able to eat anything at all for one week. Once I got over the sickness though, once I found I could eat I really started bingeing. I used to eat three breakfasts. I found I could eat so much in the mornings. I'd go for anything. It was as if I hadn't eaten for a week. I was making up for lost time I suppose. I just felt really hungry'
> (Brenda Gray).

> 'I've felt sick for a lot of the time since I've been pregnant and I just haven't been able to stop eating. I suppose it was because I had the nausea feeling really. I wish I was either sick or I wasn't sick, but I wasn't, I had the nausea feeling. The only thing that would shut it up was for me to sit there and nibble continually'
> (Claire Whitcher).

Thus, the women in this study who experienced the unpleasant physical side effects of nausea and indigestion associated with pregnancy changed their diet in various ways in order to minimise or relieve these symptoms. In such cases, pregnancy led directly to a changed type of eating practice from that of before pregnancy. The

eating strategies employed to help deal with the symptoms had an impact on their experiences regarding their weight. Strategies that involved eating less than usual meant that weight gain was low and, conversely, strategies that involved eating more than usual meant that weight gain was high. The women's reactions to their weight gains related, as I have discussed above, to their own perceptions of 'high' or 'low' weight gains. It is interesting to note here that in the first group of changed eating behaviour identified above, many women expressed positive feelings about experiencing unpleasant physical symptoms of nausea or indigestion because this meant that they had to reduce food intake and therefore would minimise weight gain. Such a reaction is probably unsurprising in a group of fat women, most of whom expressed dissatisfaction with their weight before pregnancy. Nevertheless it does indicate the extent to which fatness is abhorred by some of these women so that even experiencing ill-health is preferable to putting on weight.

A further topic that comes under the heading of the physical effects of pregnancy on diet is that of food cravings and aversions. This is included under this heading because many of the women viewed these as physical although this may not necessarily be the case. In Murcott's study (1988) of cravings and aversions during pregnancy, she found that women viewed the notion of cravings during pregnancy as self-indulgent and, as a consequence, that many women did not follow cravings. Furthermore, she found that cravings and aversions for particular foods generally corresponded to cultural notions of 'good' and 'bad' food respectively. Murcott's study was of a group of women for whom fatness was not a common feature. It was possible, therefore,

that different findings might emerge from my study given that it is concerned wholly with fat women. Indeed, this proved to be the case. While Murcott's arguments held true in the case of aversions, stark differences occurred in the case of cravings. In the case of aversions, 13 women (35%) reported no aversions at all. Of the rest, ten women (27%) reported aversions to tea or coffee and seven women (19%) to spicy and fatty foods. Only seven women (19%) had other types of aversions and these were generally not for foods that are popularly viewed as 'good' such as fruit, vegetables or protein-rich foods. Thus for this group of women, in common with those from Murcott's study, aversions were most commonly tea, coffee or fried, fatty foods, that is, food that is commonly viewed as 'bad'.

In the case of cravings, however, very different findings emerged. Not only did the majority of the women experience cravings but the sorts of foods that most of these women craved were not those that are commonly viewed as 'good'. Only seven women (19%) reported having no food cravings at all. Furthermore, only five women (13%) reported craving food that is commonly viewed as 'good', such as fruit and vegetables. Of these two groups of women, some expressed surprise at not having cravings. Others however, like the women in Murcott's study, believed that such cravings were an excuse for self-indulgence and denied themselves all cravings that were not for, what they viewed as, 'good' foods.

The majority of women, then, had cravings for foods outside of those commonly viewed as 'good'. Most common amongst these were fizzy drinks, sweets, chocolate, biscuits and snack-type foods such as crisps. A total of 25 women (67%) craved at least one such item of food. Of

this group of women, only one did not eat the food she craved and this was because such foods were prohibited to her as they were high in sugar and she was a potential diabetic. The rest of the women all ate the foods that they craved. A minority of these women were aware that they were using pregnancy as an excuse for eating foods that they would normally prohibit themselves from eating and some noted that they had 'cravings' for food whether they were pregnant or not. Nevertheless, this did not prevent them from eating such foods. The majority of the women (n20) justified their eating by referring to the notion of a craving for food. The women in this group put forward two arguments for why they should follow their cravings. Some women noted that their cravings for food were so strong that they had to have what they craved and would not feel better unless they did. Others noted that cravings were their body's way of telling them what foods they needed for their and their babies' health and therefore that such cravings should be followed. The next two quotations highlight these two justifications for following cravings:

> 'When I first got pregnant I was craving for all sorts of things like apples and candy and crisps and when I finally got them and ate what I wanted, I was fine. So I think you should eat what you crave'
> (Sarah Wells).

> 'I think things like the beetroot and the mushrooms is probably a lacking of some vitamin or iron or something from my body. And I think the only way my body can tell me is to think: oh, that's in mushrooms, so if I can get her to eat mushrooms ... Even down to these chips it may have been that my body was saying, well you do need a certain amount of fat content anyway, so perhaps I needed that'
> (Louise Marsden).

In summary, the women in this study, like those in Murcott's, had food aversions that in general corresponded to common notions of 'bad'

foods. However in the case of food cravings there were stark differences to those noted by Murcott. The majority of women in this study had food cravings and most of these cravings were for food that is commonly viewed as 'bad'. In addition, the food that was craved and eaten, for example sweets and chocolate, was often food that the women did not routinely eat. In a non-pregnant state such foods were often avoided by the women, or at least avoidance was attempted, because of fear of excessive weight gain. Indeed, where such foods were eaten this was often accompanied by feelings of guilt. However, in pregnancy, for the majority of women, the eating of such foods was in some sense legitimated. Only a minority of women in my study viewed following pregnancy food cravings as an excuse for self-indulgence as Murcott's women did. Rather, most of the women in my study justified following food cravings with reference to a physical need that their body had for particular foods.

There are several reasons why fat women might experience cravings in a different way to slimmer women. All women, whatever their size, are subject to pressure to be slim. As a result, most women are likely to be at least aware of their size and the way that what they eat contributes to this. For women who do not view themselves as fat, becoming pregnant may be a time of great concern in terms of weight gain. Although they may not view themselves as fat before pregnancy this does not mean that they are unconcerned about their weight. Indeed, the changes that some women perceive might occur as a result of a pregnancy may be feared more deeply by slim women than by fat women. Thus, it is possible that some women who do not view themselves as fat before pregnancy might seek to actively avoid this state after pregnancy

by denying pregnancy cravings. These are likely to be seen as self-indulgent, particularly by women who successfully deny themselves food at other times in order to stay slim.

For fat women, however, the situation may be quite different. Fat women experience strong prohibitions, both self-imposed and societally-imposed, on the types and quantities of food that they can eat. Furthermore, where 'prohibited' foods are eaten this is often accompanied by a great deal of guilt and remorse. However, the cultural view or stereotype of pregnancy offers fat women an escape, albeit temporary, from this. Pregnancy is a time, probably the only time, when fatness for women is legitimated to some degree and the emphasis on women's physical appearance in terms of sexual attractiveness is lifted. Fat women, then, are perhaps less likely to see cravings as self-indulgent. Denying themselves certain foods did not have the desired effect before pregnancy and thus the legitimation of eating what they want, after what may have been several years of self-denial to no effect, is likely to be a pleasing prospect. This is probably particularly so because of the notions that cravings are a physical need which removes the guilt that would be associated with eating such foods purely out of desire. Furthermore, fat women are perhaps less likely to fear post-pregnancy fatness than slimmer women, thus making the questioning of the view of cravings as a physical need less likely. These factors, I would argue, make the following of pregnancy cravings for 'bad' foods and the justification of them as a physical need greater for fat then slimmer women. It is, of course, not possible to ascertain the effect that the existence of these cravings, where they occurred, had on the women's weight during pregnancy. Nevertheless, some effect

was likely and this was seen by the women as a contributory factor affecting the differential levels of weight gain that they experienced.

In terms of the physical effects of pregnancy, then, pregnancy brought about some significant changes in the eating practices of some of the fat women in this study. Such changes, and the way that the women responded to them, appeared to be related to how the women felt about their weight during pregnancy. Thus, for example, changes brought about as a way of coping with pregnancy's physical side effects were responded to with pleasure or displeasure according to the effect that they had on weight gain. Similarly, the response to cravings or aversions appeared to have a relationship to feelings regarding weight gain and eating in pregnancy.

4.3(iv) <u>The Practical And Ideological Organisation Of Food And Eating During Pregnancy</u>

In the preceding chapter I noted some of the ways that the practical and ideological organisation of food and eating determines what food women consume in households and where, when and how it is eaten. In addition I noted how these practices contribute to making some women fat in the first place and make losing weight in the long term difficult. There were some changes that occurred in certain of these aspects of the practical and ideological organisation of food and eating as a result of pregnancy for some women in this study and it is these that I will now go on to discuss.

The majority of the women in this study (n22, 59%) reported some change in the practical and ideological aspects of food and eating during pregnancy from those of before pregnancy. In terms of the practical organisation of food and eating, changes occurred for a number

of reasons. For women experiencing their first pregnancy, leaving employment and having more time to cook and prepare food but less money to spend on it was an important feature bringing about change. I noted in the preceding chapter that many of the women in this study ate a lot of 'convenience' meals before pregnancy because of a lack of time to cook 'proper' meals due to constraints of time that arose out of being in full-time employment. However, leaving employment and becoming a full-time housewife while awaiting the birth of a first baby brought a change in this situation. Many women reported cooking 'proper' meals once they were at home with more time on their hands and the decrease in income due to leaving work was also reported as a consideration in moving from 'convenience' to home-cooked meals. The following quotation illustrates this:

> 'I cook different things now because I've got so much time on my hands now. So I don't cook him fish fingers and chips and things like that. We have, like last night we had spaghetti bolognese, or I cook a curry or a sweet and sour. Casserole things, that's what I normally cook now because I get so bored in the afternoons. I want something to do so I just cook a casserole thing'
> (Jenny Harris).

For some women in the study, even greater changes in the practical organisation of food and eating occurred during pregnancy. Three of the women who were young and single with unplanned pregnancies experienced changes in their home environment. Two of these women moved back into the parental home during their pregnancies and one moved away from the parental home to live with her boyfriend. The women who moved back into their parental homes consumed a very different diet to that which they consumed while living independently and their involvement with meal

preparation also changed. They were 'looked after' by their parents rather than themselves and this meant that they were not primarily responsible for preparing their own meals. Furthermore, the food that they consumed was 'better' because the constraints of time and money that they had experienced while living independently did not apply for their parents. For the woman who moved in with her boyfriend the reverse was true. Her situation changed from being the 'looked-after' to being the one who did the 'looking-after'. This meant that she had primary responsibility for food preparation and organisation which before had been her parents' responsibility.

In part, changes in the sphere of the practical organisation of food and eating during pregnancy reflect a slight shift in the ideological organisation of food and eating at this time. The changes noted above resulted in women being more likely to prepare and/or eat 'proper' meals rather than 'convenience'-type meals. Partly this occurred because it was more practical to do so but existing alongside these practical considerations were notions that women should eat 'proper' meals during pregnancy. In the preceding chapter I noted that the women in this study subordinated their own food needs and desires to those of, first, their male partner and then their children. The reason for this privileging of male partners in terms of food is, I have argued, ideological and reflects men's high position in the social and familial hierarchy and, conversely, women's low position in these areas. During pregnancy several women reported a slight shift in the prioritising of their male partner's food preferences. Male partners' food preferences were still viewed as important and were catered to but the women tended to put some limits on this during pregnancy and not to

subordinate their own food wants so completely as they had done before pregnancy. The women tended not to cook food for their partners that they themselves did not like as some of them had done before pregnancy. Where this did occur the women cooked themselves a separate meal and did not go without as they had a tendency to do before.

This slight shift, however, does not reflect a change in the position of women in relation to men in the social and familial hierarchy. During pregnancy the women appeared to assert their own wants in terms of food to a degree that they did not before pregnancy but this was not so much for themselves as for their unborn baby. The conditions that make it acceptable, and perhaps even expected, that women give higher priority to their own food needs during pregnancy arises from the importance society gives to the rights of the unborn child. This means that it is seen as acceptable that women's food needs are given a greater priority during pregnancy but this is not so much for the women themselves as for the unborn children that are contained in their bodies. The following quotation illustrates these points:

> 'I make sure I have a meal every day now. When I used to cook something special that he [partner] likes and I don't, I just used to have a snack like a boiled egg for myself but I don't do that now. I think I probably thought it would be better for me and the baby if I did that [have a meal rather than a snack]. The baby more than anything else I think because if I'd wanted to do it for me I would probably have done it before I was pregnant'
> (Linda Dobson).

There were no other major changes in the ideological organisation of food and eating during pregnancy than before pregnancy. Although pregnancy, as I have noted above, is a time when traditionally women are viewed as being in need of care and attention, this did not result in

any great changes in this area. While some women indulged themselves and were indulged by their partners during pregnancy with food that they might normally not have eaten, this did not lead to any fundamental change in the ideological organisation of food and eating.

The changes in the practical and ideological organisation of food and eating that occurred for some women as a result of pregnancy obviously had some impact on diet and consequently weight gain during pregnancy. For some women the effect was seen as positive in that weight gain was low but for others the reverse was true. A change in the home environment, giving some priority to their own food needs, as well as spending more time at home and having access to food and greater time to cook 'proper' meals were all likely to affect weight gain.

4.3(v) Advice

I noted above that advice from medical professionals regarding weight and eating was not given routinely to this group of fat women. Only 13 women (35%) received unsolicited advice from medical professionals. A further seven women (19%) also received advice, but this was as a result of advice-seeking on their part. As has been noted, where advice was given it was received by the women in a variety of ways. This as well as a number of other factors had an effect on whether medical advice was followed and consequently whether diet and weight gain were affected by medical advice. Here I want to discuss the extent to which medical advice was followed, the effect this had on diet and eating practices during pregnancy and its contribution to differential weight gains among the women who were given advice. In addition I will identify some of the factors that emerged as important in leading the women to follow or ignore medical advice.

Of the 13 women who were given unsolicited advice, six women either did not follow the advice at all or followed it for a short period and then gave up. The remaining seven women all attempted to follow the advice that they were given but only two adhered to the advice strictly. All of the seven women who sought advice followed it to some degree, but only one woman adhered to the advice strictly. Some women who followed the medical advice that they were given made quite big changes in their diet. There were two main changes in diet that occurred for these women. First, there was a change in the sorts of foods eaten at mealtimes, so that certain foods that were regularly eaten before pregnancy were omitted from the diet and others which had not been eaten before pregnancy were included. This meant that, in some cases, there was a complete change in the composition of meals from that of before pregnancy. Secondly, there was a change in the number of meals eaten a day. Before pregnancy some women had consumed very little and limited themselves to one meal a day. Some women received medical advice that urged them to eat three regular meals a day and thus women following this advice experienced a great change in food consumption. For other women, however, changes were less dramatic. For most, advice could be followed to a limited degree without making any dramatic changes in the foods that they ate or the daily mealtime pattern. Following advice for them entailed merely cutting down on particular foods, such as potatoes, bread and cakes, and eating more of other foods, such as fruit and vegetables.

Following advice, whether this resulted in a big change in women's diets or merely an incorporation of different foods into an already existing diet, had an effect on weight gain that was not always viewed

as positive. While some women felt that following advice had led to a lower level of weight gain than might have otherwise occured, others found this not to be the case. In fact five of the fourteen women who followed medical advice regarding weight and eating during pregnancy noted that following advice had a negative effect on their weight to some degree. The four following quotations illustrate how medical advice received during pregnancy can have a negative or positive effect. The first two quotations are from women for whom following advice had what they viewed as a positive effect. The first is from a woman who changed her diet drastically as a result of advice and the second from a woman who incorporated changes within her existing diet:

> 'My doctor said: "You can't diet when you're pregnant but try not to put on any weight ... try to cut out things like cakes and stuff like that, try to eat healthily". Well, that's what I've tried to do. I've changed my diet completely. I have a much more healthy diet and I'm conscious of everything I eat'
> (Josie Robbins).

> 'They [at the ante-natal clinic] asked me how I was going to keep my weight down and I told them about how I was trying to eat less potatoes and more fresh vegetables and they said that was fine. ... I eat just the same as before really but I have a bit less on my plate and I have fresh vegetables rather than tinned, and more fruit'
> (Judith Osborne).

The second two quotations are from women for whom following advice had what they viewed as a negative effect. The first of these is from a woman who changed her diet drastically and the second from a woman who incorporated changes within her existing diet:

> 'They [at the ante-natal clinic] said: "You don't eat meat, are you getting enough protein? You should have plenty of milk and cheese". So I started having dairy products. I don't normally have things like that because they're very fattening but because they went on about it you feel like you should be doing it.... I mean, when it's your first baby you do take notice of what they tell you to do but I

wouldn't eat like that again. I've just put on so much weight and I don't think it was necessary, I think I could have eaten other things. They should have given me some different advice because I've got a weight problem anyway' (Teresa Browne).

'They [at the ante-natal clinic] said: "What have you been eating?" and I told them and they said: "Well the baby's going to take all your calcium as well so you need to eat more food for yourself. So my mum's cooking lots of meat, lots of vegetables and that and I have bigger portions' (Anne Walker).

The above quotations demonstrate how following advice during pregnancy can have an impact on eating practices and weight gain. In part whether weight gain is large or small as a result of following advice is connected to how advice is interpreted. Women who have large weight gains as a result of following advice may do so because they follow advice in a way that was not intended when it was given. Some of the women, however, felt that the problem was caused not by the misinterpretation of advice but by being given advice that was inappropriate for them. They felt that this occurred because medical advice regarding weight and eating in pregnancy focuses on the baby's health and well-being rather than the mother's. Thus, the sort of diet that a fat woman might be advised to consume for her baby is not necessarily the sort of diet that would be best for her in terms of keeping weight gain to a minimum. In fact many of the women, both those who received advice and those who did not, reported that they would have liked some specific advice regarding diet in pregnancy that had their bodies and themselves as the focal point rather than their babies. However, whether weight gain connected to advice is due to inappropriate advice being given to some women or misinterpretation of advice is not at issue here. It is sufficient to note that following medical advice

regarding weight and eating during pregnancy can have an effect, either positive or negative, on weight gain during pregnancy.

Medical advice seemed to have some impact on changing eating patterns and consequently on differential weight gains during pregnancy for some of the women in the study but overall the impact of advice was less important than might have been expected. The major reason for this was that medical advice-giving (whether sought or not) was less widespread than medical and ante-natal literature indicated. In addition, not all the women who received advice actually followed it. Only 14 women (38%) followed advice that they were given and the majority of these did not follow such advice strictly. I noted above some of the reasons why medical advice regarding weight and eating during pregnancy is not routinely given to fat women. Here, I would like to concentrate briefly on some of the reasons why, where such advice is given, it is not followed, or not followed strictly.

Two groups of issues emerged as important in determining whether advice was followed or not. The first is concerned with whether the women felt medical advice *should* be followed and the second with the more practical question of whether medical advice *could* be followed. In terms of the first of these, the acceptance of medical advice as valid was crucial. This appeared to be connected to social class and to previous experience of pregnancy. Several studies have noted that working-class people see lay advice as more credible than medical advice and as a consequence are more likely to follow lay than medical advice (Blaxter and Paterson, 1983). Social class appeared to be one of the features determining whether the women in this study followed medical

advice and particularly whether they followed advice strictly. The middle-class women were much more likely to follow medical advice, and to follow it strictly, than the working-class women. There was, however, no evidence that working-class women substituted lay advice for medical advice. Previous experience of pregnancy also appeared to be important. Those women who had not experienced pregnancy before and those women who had experienced a previous bad outcome of pregnancy, such as repeated miscarriage or a stillbirth, were most likely to follow medical advice. Women who had experienced at least one or more successful pregnancy tended to rely more on their own judgement than on the advice of the medical profession.

In terms of the more practical issue of whether advice *could* be followed, some points raised by Murcott (1982b) are of relevance here. Murcott argues that advice regarding diet during pregnancy given by medical professionals is hard to follow because such advice does not fit readily into the way that food and eating are organised in households. She notes that the advice that medical professionals give to women comes from a nutritional framework and that this ignores the social context of food and eating in households. Murcott's arguments may explain, in part, why so few women strictly followed the advice that they received. The majority of women reported receiving advice that can be seen as being located in the nutritional framework described by Murcott. Women were often advised to eat or avoid groups of foods under nutritional headings such as 'more protein', 'more iron' or 'less carbohydrate'. As well as this being inappropriate to the social context of eating, such advice may not have been understood fully. Even where women were advised what specific foods to eat or avoid, the advice was given in the

form of a list of foods and again, as Murcott notes, this has little relevance to the social context of food and eating. Thus, for most women the changes brought about by following advice tended to be slight. They invariably involved adding foods to, or excluding foods from, their existing diet rather than a complete change in diet.

A total of 15 women (40%) received some lay advice about eating during pregnancy. The lay advice that the women received could be divided roughly into two groups according to the type of advice and its source. The first type of advice generally came from friends, work colleagues or elderly female relatives, usually grandmothers. This advice was in the form of encouragement to 'eat for two' or to consume large amounts of particular foodstuffs, such as, 'a pint of milk a day'. The second type of lay advice came from mothers or older sisters and usually consisted of encouragement to eat less food in general or to eat particular 'healthy' types of food such as fruit and vegetables. The first type of advice is typical of that which pregnant women are urged by hospital ante-natal literature to ignore. The second type of advice largely corresponds to the advice contained in such literature. A total of six women received the first type of advice only and a further six women received the second type of advice only. Three women received both types of advice.

In general, lay advice appeared to have little impact on the women's diet and consequently their weight gain during pregnancy. In only a few cases was lay advice followed to any great degree. The women's views on diet during pregnancy seemed to correspond to current nutritional thinking in this area. This did not mean that they all ate 'well' in nutritional terms during pregnancy. However, it did mean that

they could identify 'bad' and 'good' advice about eating. If women ate 'badly' during pregnancy this was largely as a result of their food desires not as a result of being given and following 'bad' advice. Conversely, if women ate 'well' during pregnancy and followed 'good' advice this was because it reinforced the women's notions of what they felt was a 'good' diet.

In summary, then, the women in this study achieved a variable level of weight gain by the 30th week of pregnancy. A total of 20 women achieved average weight gain, nine women achieved below average weight gain and eight women achieved above average weight gain. Five factors emerged as important in explaining the differential weight gains for this group of women during pregnancy: physiological factors; pregnancy as a life event; the physical effects of pregnancy; the practical and ideological organisation of food and eating; and medical and lay advice. The last four of these factors are concerned with eating and the above discussion has illustrated the changes that can take place in women's eating practices during pregnancy from those of before pregnancy. For fat women the changes that take place in eating practices as a result of pregnancy are very important given most fat women's concern about weight gain and the association between food consumption and weight gain. For the fat women in this study, some of the changes in eating practices during pregnancy were managed in a specific way that related to the women's feelings about their weight. As I have noted, the management of some of the changed eating practices in pregnancy may be quite different for fat women than for slimmer women.

## 4.4 CONCLUSION

I noted in the preceding chapter that before pregnancy the majority of the women in this study were dissatisfied with their weight. In addition, I noted that the women's food consumption was influenced by their social roles and that these made it easy for them to become fat in the first place and made it difficult to lose weight in the long term. However, during pregnancy some marked changes appeared to occur. First, a majority of the women reported a change in how they felt about their weight. The reasons for these changes in feelings regarding their weight appeared to be primarily related to one of two factors: either the changed social image of women during pregnancy that made fatness more acceptable, or the women's views of their pregnancy weight gains as 'good' or 'bad'. The second area where change was reported was in the women's experiences regarding their weight and eating. The women experienced differential weight gains and a number of factors were identified as contributing to the amount of weight gained. Most of these factors related to eating and there was evidence that pregnancy led to some changes in eating practices from those in existence before pregnancy. Thus it seems that, for the majority of women in this study, pregnancy led to changed feelings regarding their weight and changes in eating practices. Some of these changes, or at least the way that they were managed, appeared to be specific to fat women. As I have noted above, intense concern about weight is often a constant experience for fat women and indeed this was the case for many of the women in this study. Thus, their feelings and experiences about their weight and eating during pregnancy are likely to be very much related to their feelings and experiences in these areas before pregnancy. Obviously,

such feelings and experiences are very different to those of slimmer women.

Pregnancy, then, seemed to lead to changes in the women's feelings and experiences regarding their weight and eating, and some of these changes were specific to fat women. In addition, the changes that pregnancy brought about in these areas led to further changes in feelings and experiences regarding weight and eating. The women's changed feelings about their weight which resulted from being pregnant were also connected to the amount that they ate, as was the amount that they ate (because this contributed to weight gain) connected to how they felt about their weight. Some examples may help to illustrate these points. Some women, for example, felt better about their weight during pregnancy because of the social image of women during pregnancy which legitimates fatness to some degree. Thus, in these cases, pregnancy led directly to improved feelings about weight. However, in addition, these feelings led to changed eating behaviours. Some of these women ate quite differently in terms of types of foods and amounts during pregnancy than they had done before pregnancy because they felt that they were 'allowed' to be fat and therefore could eat what they wanted. Other women experienced the situation the other way round. Some, for example, experienced pregnancy as a stressful event and turned to food to help them to cope. Their eating patterns, then, were brought about as a result of pregnancy. In these cases, changed experiences regarding their eating which occurred as a result of pregnancy led to particular feelings regarding their weight. Such feelings were, in general, quite negative as weight gain resulting from such eating behaviour was likely to be seen as 'high'. Thus, the three important variables here are

pregnancy, weight and eating. These three variables appeared to inter-relate with each other in shaping the experiences of the women. Again, it seems that fat women's experiences are likely to be different than other women's because of the significance attached by them to weight and eating.

Using the areas discussed in this and the previous chapter I intend now to go on to examine what happened to these women's feelings and experiences about their weight and eating *after* pregnancy. The following points are of relevance in examining this: first, the majority of women in this study had long histories of dieting and expressed long-term concern and dissatisfaction regarding their weight; secondly, the women's social roles made losing weight in the long term difficult; and, thirdly, many of the women experienced a change in both how they felt about their weight and in their eating practices during pregnancy. In the next chapter I will go on to examine whether the women's feelings and experiences regarding weight and eating reverted back to those of before pregnancy or whether changes occurring during pregnancy continued in some, if not all, areas.

# CHAPTER FIVE: FEELINGS AND EXPERIENCES REGARDING WEIGHT AND EATING AFTER PREGNANCY

## 5.1 INTRODUCTION

To examine their feelings and experiences after pregnancy the women upon whom this research is based were interviewed at around six weeks after childbirth. This particular timing was chosen as it is seen by many commentators to mark the point when women have returned to 'normal' to some degree after the childbirth event. This return to normality is seen to be in the physical, emotional and practical senses. In addition, some of the ante-natal literature notes that pregnancy weight gain will probably have been lost and that a return to somewhere near the pre-pregnancy weight is likely by the six week stage (Health Education Authority, 1984).

The extent to which pregnancy weight is likely to return to somewhere near 'normal' by the sixth week after childbirth is debatable. Some of the medical literature notes that factors such as pregnancy weight gain and whether the mother is breast-feeding or not are important in this (Rookus et al, 1987; Greene et al, 1988). This will be discussed in greater detail below. However, whether such weight loss is likely at this point after childbirth is not the important point here. Rather, it is the *expectation* that weight loss will have occurred. Indeed, most of the women held this view and their feelings about their weight were strongly influenced by, among other factors, the amount of pregnancy weight gain that was lost by the time of the second interview. This will be discussed in greater detail below in the section on the women's feelings about their weight. Here I want to

focus briefly on the actual amount rather than how these were interpreted. In listing these amounts it is important to bear in mind that their significance lies not in the actual amounts but in the fact that most of the women expected or hoped to return to something near to their pre-pregnancy weight at this point. Again, details of the women's weights were obtained from self-reports and therefore were not necessarily entirely accurate. However, these weights are given only as a way of illustrating the broad differences in weight gain or loss and as a way of introducing how these influenced the women's feelings about their weight.

The following table shows the women's actual weights after pregnancy and the amount they had gained or lost compared with their weight before pregnancy. The women's weights ranged from 69kg. to 130 kg. with the mean average weight being 94kg.. In the majority of cases the women's weights had changed from those reported before pregnancy. However, in 16 cases (43%) the women reported weight gains or losses that meant that their post-pregnancy weight was within 6kg above or below their pre-pregnancy weight. These women experienced losses or gains in weight that resulted in their weight after pregnancy being quite close to their weight before pregnancy. For the other women in the sample changes were more dramatic. A total of 21 women (57%) reported weight losses in excess of 7kg (n7) or weight gains in excess of 7kg. (n14). The highest weight loss comparing post-pregnancy with pre-pregnancy was reported as 35kg. and the highest weight gain was also reported as 35kg..

Table 14

Actual Weight And Weight Changes At Six Weeks

After Pregnancy Compared With Before Pregnancy

| | Weight Change | | | |
|---|---|---|---|---|
| | Weight Loss 7kg. or more Up To 6kg. | Weight Loss/Gain | Weight Gain 7kg. Or More | Total |
| Weight: | | | | |
| 69-79kg. | 1 | 1 | 1 | 3 |
| 80-89kg. | 2 | 3 | 1 | 6 |
| 90-99kg. | 3 | 9 | 6 | 18 |
| 100-130kg. | 1 | 3 | 6 | 10 |
| Total | 7 | 16 | 14 | 37 |

## 5.2 FEELINGS REGARDING WEIGHT

As I noted in chapter three, all the women in this study could be defined, using medical criteria, as overweight to some degree before pregnancy. While individual women's weights varied after pregnancy from those of before pregnancy, none of them changed sufficiently to put them outside of this definition. I also noted that all of the women perceived themselves as fat before pregnancy to some degree and that most (81%) were dissatisfied with this state. There was little change in the women's perceptions of themselves as fat after pregnancy compared to before. While some women reported quite drastic changes in their weight after pregnancy compared to before pregnancy they all still considered themselves as fat to some degree. However, many women

reported a change in how they felt about their weight after pregnancy compared to how they felt about it before pregnancy. These changes in satisfaction did not seem to be particularly related to levels of satisfaction with weight experienced *during* pregnancy. Indeed, feelings about weight during pregnancy appeared to be completely separate and almost unrelated to feelings experienced both before and after pregnancy. This is probably unsurprising given that pregnancy is a unique experience for women in that they are both perceived and treated in very different ways than they are at all other points in their lives. This makes pregnancy a special time but one that has a fixed time limit. Thus it is segregated out from the rest of life and therefore likely to be viewed differently by women experiencing it.

A total of 12 women (32%) reported feeling the same about their weight after pregnancy as they had done before pregnancy. For all these women feeling 'the same' meant that they were dissatisfied with their weight to some degree. A total of seven women (19%) reported feeling better about their weight after pregnancy than they had before pregnancy. For most of these women this meant that they were still dissatisfied with their weight although to a lesser degree than they had been before pregnancy. However, two of the women in this group had reported feeling satisfied with their weight before pregnancy and so improved feelings for them meant greater satisfaction rather than a reduction of dissatisfaction. A total of 18 women (49%) reported feeling worse about their weight after pregnancy than they had done before pregnancy. Four of the women in this group had reported feeling satisfied with their weight before pregnancy and this change in feelings

led to dissatisfaction regarding their weight for them. All the other women in this group reported feeling dissatisfied before pregnancy and this change was, therefore, a worsening of these feelings of dissatisfaction. Thus, the great majority of women in this study felt dissatisfied with their weight after pregnancy to some degree. This dissatisfaction can be illustrated by the fact that 26 of the women (70%) were on weight-reducing diets by the time of the second interview. A further eight women (22%) planned to diet soon after the interview. Only three women (8%) were not actually dieting or planning to diet.

There were five major factors that emerged as important in contributing to feelings of satisfaction or dissatisfaction with weight after pregnancy. The women themselves identified and articulated some but not all of these five factors; others have been identified through interpretation of the data. The factors identified were: first, the amount that a woman weighed after pregnancy; secondly, the change in body shape or appearance; thirdly, the ability to fit into pre-pregnancy clothes; fourthly, comments received from kin and medical professionals; and fifthly, emotional well-being. Table 15 sets out the numbers of women who made reference to the five factors listed above as important in contributing to their feelings about their weight after pregnancy. The women are divided into groups in the table according to their post-pregnancy feelings about their weight. As can be seen from the table, the factors were not mutually exclusive: actual weight was an important factor in 31 cases; appearance in 15 cases; clothes in 16 cases; medical and lay comments in 26 cases; and, emotional well-being in four cases.

Table 15

Factors Contributing To Feelings About Weight After Pregnancy

| | Factors | | | | |
|---|---|---|---|---|---|
| | Weight | Appearance | Clothes | Comments | Emotional Well-Being |
| **Feelings:** | | | | | |
| Better Than Before Pregnancy (n7) | 7 | 2 | 4 | 4 | - |
| Same As Before Pregnancy (n12) | 10 | 4 | 1 | 7 | - |
| Worse Than Before Pregnancy (n18) | 14 | 9 | 11 | 15 | 4 |
| Total | 31 | 15 | 16 | 26 | 4 |

5.2(i) Actual Weight After Pregnancy

The great majority of women in the study noted that their feelings regarding their weight after pregnancy were related to the amount that they weighed. A total of 31 women (84%) identified this as a major or contributory factor in their feelings about their weight. For some women the effect of this was positive in that they weighed less than they expected to after pregnancy. In fact all but one of the seven women who reported feeling better about their weight after pregnancy than before noted this. In most cases the major part of this weight loss was attributed to the birth of the baby. These women noted that they lost a lot of weight straight after the baby's birth and most of them had continued to lose weight since then. All of these women had low weight gains during pregnancy and only one of them had gained in

excess of 7kg. by the 30th week of pregnancy. This factor probably contributed to their quick weight loss after childbirth. However, while all these women expressed pleasure at the amount of weight that they had lost, this did not lead to their feeling satisfied and content with their weight. Rather, this appeared to have the effect of encouraging them to attempt to lose more. All but one of these women were on diets of some sort and in some cases these diets were quite extreme in a desperate attempt to lose still more weight. The following quotation was typical of the responses of this group of women regarding their weight loss:

> 'I lost all my birth weight when I gave birth. I put on a stone and a half [10.5kg.] and I lost that plus a little bit more. I went up to 17 stone [110kg.] and I went right down to 15 stone [96kg.] by the second week. ... I'd like to lose a bit more now though'
> (Judith Osborne).

For the other 24 women in this group of 31 women under discussion in this section, the amount that they weighed after pregnancy led to, or contributed to, their feeling the same or worse about their weight than they had done before pregnancy. For all but one of these women this meant that they were dissatisfied with their weight to some degree. All but one of these women were actually dieting or planning to diet. Not all these women weighed more than they had done before pregnancy but even where weight loss had occurred this did not lead to their feeling any better about their weight because they still felt that they weighed more than they should have done. The dissatisfaction that this group of women experienced was linked to the amount of weight that they had retained after their pregnancies which was in excess of what they wanted or expected to weigh. The level of dissatisfaction was varied and the

women who reported the greatest degree of dissatisfaction in the sample were in this group. Where dissatisfaction was extreme, this appeared to be related to the degree of weight gain. The women who experienced dissatisfaction to a great degree and were extremely distressed by it were those who weighed considerably more after pregnancy than before. Others were dissatisfied but did not experience this in such an extreme way. These women tended to have weight gains that were smaller in comparing pre- pregnancy and post-pregnancy weight. The following quotation illustrates the high level of distress regarding weight felt by some of the women who had high weight gains and the way that the amount that they weighed lay at the centre of this distress:

> 'I'm disgusted. I feel much worse than before I was pregnant. I feel really, I tend not to look in the mirror so much now, but when I do I'm disgusted with myself. ... I lost a stone [7kg.] that came off straight away but I've still got a long way to go. I still get on the scales now and I think: oh, this is terrible. ... It's been much harder than I thought it would be. I thought I'd lose it easily. I thought it would come off straight away. It's really strange, you think it's an excuse when you're pregnant, but it's not. ... I started a diet today. Whether I'll hang in there, I don't know. I hope to, but it's difficult'
> (Brenda Gray).

For the majority of women, then, the actual amount that they weighed after pregnancy was a factor in their feelings regarding their weight. Some women who weighed less after pregnancy than before felt better about their weight and some women who weighed more felt worse. The great majority of women who noted that the amount that they weighed was a prominent factor in their feelings about their weight reported that they felt dissatisfied with their weight to some degree. Thus, even weight *loss* did not lead to feelings of *satisfaction*. Rather the

women reported feeling more or less *dis*satisfied. Evidence for this is the large number of women who were on a diet, or who were planning to start on one. The dissatisfaction with the amount that they weighed after pregnancy reported by the women is unsurprising. Most of these women expressed a great degree of dissatisfaction with the amount that they weighed before pregnancy. Thus, weighing the same or even more after pregnancy is not likely to lessen that dissatisfaction. Even losing weight after pregnancy would be likely to lead to satisfaction only if weight loss was to a degree that it left the woman at her 'ideal' weight.

5.2(ii) Physical Changes: Changes In Body Shape And Appearance

A total of 15 women (40%) reported that a change in body shape or in their physical appearance as a result of pregnancy led to, or contributed to, their feelings about their weight after pregnancy. For most of these women such changes were seen as negative and led to their feeling the same or worse about their weight after pregnancy than they had done before pregnancy. Only two of the women who reported changes in body shape or appearance felt better about their weight after pregnancy. The women's responses concerning body shape and appearance came into two categories and it is important to make a distinction between these. One set of responses was concerned with changes in body shape and appearance and their effect on a personal level and the other with changes in body shape and appearance and their effect within a wider social context. The first one of these is concerned with personal relationships that take place in the private sphere of the home and is related to the social image of women as partners and mothers. The second is concerned with wider social relationships that take place in

the public sphere outside the home and is related to the social image of women as a group.

(1) Appearance And The Private Sphere

The first area, that of changes in body shape and appearance and their effect on personal relationships within the private sphere of the home, relates to women's views of themselves as sexual partners. There is some evidence in the literature on motherhood that mothers are not culturally viewed as sexual beings (Oakley, 1980; Welburn, 1980). Several women noted that the changes in their roles brought about by first-time motherhood made it difficult for them to view themselves as sexual. A clear example of such difficulties was in cases where women breast-fed their babies and some women reported conflicting feelings that arose from this regarding whether their breasts were sites of sexual pleasure to be shared with partners or sources of sustenance to their babies.

However, it was not just a change in roles that brought about conflicts regarding women's feelings relating to their sexuality. Additionally, all the fifteen women in this group reported that changes in their bodily appearance as a result of pregnancy and childbirth made it difficult for them to view themselves as sexually attractive. This was not reported by first-time mothers only. In particular this lessening of feelings of sexual desirability was seen in relation to their partners. This was because these were the men that the women were relating to sexually and who therefore saw the women in their naked state whereas this situation could be avoided with others. It is unsurprising that the women saw themselves as sexually unattractive

after pregnancy given that the changes in bodily appearance that occur as a result of pregnancy, such as loose skin, stretch marks and sagging breasts, are associated with unattractiveness. The significance given to the change in women's physical appearance after pregnancy is a further illustration of how the definition of women in terms of sexual attractiveness is played down in pregnancy but re-appears immediately afterwards. The following quotations illustrate the extent to which many of these women felt unattractive (and therefore not sexually desirable) as a result of the changes in their bodily appearance that occurred as a result of pregnancy:

> 'While I was pregnant and I had stretch marks it seemed to be all part and parcel of being pregnant and now it just seems horrific'
> (Alison Norris).

> 'I feel all stomach now. It's like a man with no teeth in, it's all floppy and horrible. I'm not too worried what I weigh, it's what I look like and I look horrible'
> (Sandra Crocker).

Thus, for many women, changes in roles or changes in bodily appearance as a result of pregnancy resulted in their feeling unattractive and not sexually desirable.

The finding that changes in bodily appearance led to many of the women feeling that they were less attractive and less sexually desirable after pregnancy is unsurprising and is unlikely to be unique to fat women. However, two aspects concerning this are somewhat surprising and need to be addressed. These are specifically relevant to the fact that this group of women are fat women. The first is that the majority of women in this study did not view themselves as sexually attractive before pregnancy and the major reason for this was that they were not slim. Thus, it might be assumed that the effects of pregnancy on their

bodily appearance might be received in a less dramatic way than on a slimmer woman. In addition, a move to 'mother' from 'lover' might be less dramatic for fat women who may find the 'mother' role more suited to their physical characteristics. The second aspect is that nearly half of the women (n7) who reported that their physical appearance after pregnancy affected how they felt about their weight had given birth to their second or subsequent child. Given that these women had experienced the after-effects of pregnancy before it would seem likely that bodily changes would be not only expected but also less dramatic than for first-time mothers. Thus such changes would be likely to be received as no great surprise and to contribute little to their feelings about themselves.

The following three factors are of relevance in explaining why some fat women might feel unhappy about their weight after pregnancy in terms of their physical appearance and also why past experiences of this do not prevent such feelings recurring. First, having a baby, whether it be for the first, second or subsequent time, marks a new beginning in women's lives. It is often seen as a time for re-assessment and a time to take stock of one's life and start afresh. Cultural romantic notions and stereotypes of motherhood contribute to this view and encourage women to strive to be the 'ideal' mum, not just in behaviour but also in appearance (Welburn, 1980). It is unsurprising, therefore, that areas of one's life that have seemed problematic and constraining in the past (such as being fat) are likely to be re-assessed and to take on a new significance at this time. Thus, for fat women, physical appearance may become increasingly important after pregnancy because of a desire to start afresh and to fit in with a particular stereotype of motherhood.

The second reason is somewhat simplistic but important none the less. It is that while many of the women felt bad about their weight before pregnancy, this did not mean that they could not feel worse about their weight after pregnancy. This applies to women experiencing a first as well as a subsequent pregnancy. It is not that these women viewed themselves as sexually attractive before pregnancy and as not sexually attractive after pregnancy but rather that the changes in physical appearance that occurred as a result of pregnancy led to their feeling *less* sexually attractive after pregnancy. In the following quotation, Brenda Gray discusses how she felt she had no 'right' to be sexual before she was pregnant because she was fat and how much worse she feels since the birth of her baby, thus implying that she has even less 'right' to be sexual now:

> 'I feel much worse [about my weight] than before I was pregnant. ... It's no fun being big to me, you know. I mean it doesn't look nice. I mean, you can get stockings and suspenders for big people can't you, but I mean, to see myself in them, I mean you look in the mirror and it would just be like, well it would be ridiculous. I mean Peter says to me: "That looks stupid, it doesn't turn me on". So I just wouldn't bother with things like that. I mean, it's like on my wedding day ... I wore stockings and suspenders and I looked at them and I thought, even though I was only 13 stone [83kg.] then, I still didn't feel right in them. You know, I think you should be thin to wear that sort of thing'
> (Brenda Gray).

The third factor is that, while some women saw the changes in physical appearance brought about by pregnancy as important in how they felt about themselves in terms of sexual attractiveness, others did not. Several women noted that changes in their bodily appearance made no difference to them because they were 'fat anyway'. The difference between these two groups of women seems to be that one had made the

transition from 'lover' to 'mother' and had given up aiming for sexual attractiveness because they felt their size prohibited them from ever achieving this, while the other group had not given up aiming for this. For the first group it seems likely that they embraced the 'mother' image quite readily given that it allowed them an alternative but acceptable image of womanhood, but for the second group it seems likely that they still craved 'normality', that is, to be sexually attractive or, put another way, slim. For this latter group of women the physical changes bought about by pregnancy were likely to leave them feeling the same or worse about their weight given that these changes would be likely to result in their feeling just as far, or even further, from their goal. This is probably no different whether women are experiencing a first or subsequent pregnancy.

(2) Appearance And The Public Sphere

The second area where women noted that changes in their physical appearance affected how they felt about their weight relates to the public, rather than the private, sphere and is connected to the social image of women as a group. As I have argued, women as a group are defined by their sexual attractiveness except during pregnancy. After childbirth the social image of women in terms of sexual attractiveness becomes dominant once more and women who are mothers are not viewed *socially* in a different way to women who are not mothers. Partly this may be because women who are mothers cannot always be identified as such because they cannot always have their children with them. There is, therefore, not the same scope for mothers to be defined differently in social terms to non-mothers.

This area of the social image of women in the public sphere also relates to feelings of sexual attractivenes as the social image of women in the private sphere did. However, here the relationship is less direct. In the preceding discussion the women felt less sexually attractive because they felt that their bodies in their naked state did not look as they 'should'. In the public sphere, bodies are not on display in the same way and it is sexual attractiveness in the sense of general appearance that is seen as important. The emphasis on general appearance in defining sexual attractiveness in the public sphere means that there is the possibility that some women could feel unhappy about their appearance in the private sphere but happy about their appearance in the public sphere because when clothed their body conforms to cultural notions of attractiveness. However, only one woman in this group followed this pattern. This woman weighed less than she had done before pregnancy and it was this that enabled her to feel better about her weight and appearance in public although she still felt unhappy about how her body looked when naked. The other women all noted that they felt unhappy about their appearance in both spheres. Although the reasons for this dissatisfaction varied slightly in each sphere, the major unifying reason in each was body-size. They experienced this dissatisfaction in terms of appearance in much the same way as they had done before they became pregnant.

Several women noted that they felt a need to look attractive in public that went beyond that experienced before pregnancy. This intensifying of feelings seemed to relate to issues identified above: those of the stereotype of motherhood and the way that motherhood is viewed by some women as a new beginning. As I have noted, the social

image of motherhood perpetuates ideas not only of how mothers should behave but also of how mothers should look (Welburn, 1980). For new mothers, feeling that they do not even look as they 'should' induces feelings of failure in the role of mother. Indeed, this is not only the case for first-time mothers. There may be even more pressure on second-time (or more) mothers to cope with a new baby, toddler and possibly other children and yet still to look good and behave as a 'proper' mother should. The view that motherhood marks a new beginning in a woman's life is likely to compound these feelings. The following quotations are examples of this:

> 'I think I feel more conscious of it [her weight] than I did before I was pregnant ... I wasn't bothered one way or the other about it then but now I think, yes, I've had a baby and now I could do with losing a bit of weight ... then I'd feel I looked a bit better and would probably feel a bit better'
> (Linda Dobson).

> 'I've become much more of a smarter dresser now. I make much more effort because I think now I've lost this weight and I feel much more confident and I want to look nice and that's also to do with being a mother of two. I want to look nice and not feel I've given up just because I've got two kids'
> (Katie Price).

In summary, then, a number of women noted that a change in their physical appearance contributed to their feelings about their weight after pregnancy. These changes had an impact in the private and public spheres of life. Changes in the private sphere were concerned with a change in actual *bodily* appearance and changes in the public sphere with general appearance. Changes in both these areas related to the social images of women and the emphasis on women's physical attractiveness. For most of the women, physical changes had a negative effect resulting

in their feeling the same or worse about their weight than they had done before pregnancy. This seemed to be both because their bodies' appearance had changed resulting in their appearing less 'sexually attractive' (in conventional cultural terms) than before and also because of increased pressure to conform to stereotypes of attractiveness as a result of motherhood. It seemed that for fat women these changes were acutely felt because of pre-existing dissatisfaction with their weight which manifested itself as a dissatisfaction in terms of appearance.

5.2(iii) Buying And Wearing Clothes

A total of 16 women (43%) reported that buying and wearing clothes were major factors in contributing to their feelings about their weight after pregnancy. This topic relates to the one discussed above, that of personal appearance and sexual attractiveness because clothes are integral to the presentation of an attractive appearance for women. As was noted in chapter three, fat women have a problematic relationship with clothes: they feel prohibited from wearing certain types of clothes and because fashionable clothes are designed primarily for slim women they find shopping for clothes a difficult and often humiliating experience.

Buying and wearing clothes and personal appearance were seen as important issues regarding the women's feelings about their weight before pregnancy and for many women the situation was unchanged after pregnancy. However, one new issue concerning clothes did emerge after pregnancy and this was viewed as very important in contributing to the women's feelings about their weight. This issue was whether the women could fit back into their pre-pregnancy clothes. The achievement of

this appeared to be seen as a sign that they had got back to their pre-pregnancy weight and shape and that they had not gained any extra weight as a result of their pregnancy. This situation was the minimum requirement of most of the women in this study as they all hoped to achieve no weight gain after pregnancy and indeed some hoped to weigh less than before pregnancy. The ability to fit into pre-pregnancy clothes was, therefore, of obvious importance. The achievement of this goal was met with joy and elation and, conversely, failure to achieve this was met with unhappiness and in some cases despair. For some women, the failure to fit into pre-pregnancy clothes (which they interpreted as representative of weight gain) led to an increase in feelings of lack of confidence and a feeling of not wanting to participate in social life.

The problem was not merely fitting or not fitting into clothes but rather fitting into clothes *properly* so that the women felt that they fitted in the same way as they had done before pregnancy. Thus, women who found that they could 'just about' get into their pre-pregnancy clothes expressed dissatisfaction in much the same way as those who could not get into them at all. For some women the failure to fit into their pre-pregnancy clothes was compounded by the fact that they had expected to lose weight immediately after childbirth. As a result of these expectations they were very disappointed at the slowness of weight loss which they measured by a failure to fit into their pre-pregnancy clothes. The following quotations highlight these various reactions regarding the ability to fit back into pre-pregnancy clothes:

> 'This is the second day I've had my jeans on and the first day I found I could put my jeans on, I phoned Derek up at work. Because I've been wearing my tracksuit bottoms and I

tried my jeans on and I just couldn't believe it. I woke Natalie [her daughter] up and told her too. I went out, I thought: I'm not staying in now I've got my jeans on, I'm going out. I was so pleased with myself'
(Christine Barnes).

'I can get into them [her clothes] but it's just all this bit in the middle. I mean I can get into them but they stick out and it doesn't look very nice'
(Amanda Spelling).

> 'I'm still in maternity clothes. It's been much harder than I thought it would be. ... When you've got to borrow your mum's dress to go out then things must be pretty bad. I'm not bothered about going out if I can't look nice'
> (Brenda Gray).

I noted in chapter three that before pregnancy a number of women reported keeping clothes that no longer fitted them as a result of weight gain and that these clothes seemed to serve as a reminder and a punishment of what they once were and what they had now become. A similar situation appeared to arise after pregnancy for many of these women. All but four of the 16 women in this group noted that they could not get back into their pre-pregnancy clothes properly. All of these women were reluctant to buy any new clothes, even when they could afford to, and most refused to do so. They wore the clothes that they had worn when pregnant, or large, baggy, often old, clothes. The women did not feel happy wearing these clothes and the wearing of them was seen as a temporary measure and served as a kind of punishment and incentive to lose weight. These women kept trying to lose weight and repeatedly tried on their pre-pregnancy clothes to test the success of their attempts. Regaining their pre-pregnancy weight, as symbolised by fitting into pre-pregnancy clothes, was, then, their goal.

For some women, the amount of weight that they needed to lose to get back to their pre-pregnancy weight was large and for most women

weight-loss seemed slow. The effect of repeatedly trying on pre-pregnancy clothes and finding that they did not fit was experienced quite negatively by all the women. As Rachel Hardwick explains:

> 'I can't get into any of my clothes and if I can't get into them they get kicked across my bedroom floor in temper or they get thrown at the dog. I mean, I've been on the diet okay, and, alright, I might have done a couple of sins, but I've been pretty good, but I'm just not getting anywhere. The scales haven't even moved'
> (Rachel Hardwick).

The few women who did buy new clothes after pregnancy because they could not fit into any of their pre-pregnancy clothes generally did so in an attempt to 'look nice' and to enable them to feel better about themselves. The result of this was, however, often negative. Buying clothes after pregnancy was reported in the same problematic way as it was before pregnancy. Indeed, the experience was in some ways even more difficult because the women felt that they were in 'worse shape' than they were before pregnancy. Finding clothes to fit, looking at themselves in the mirror and having to face up to the fact of their weight, size and shape and their perceived unattractiveness resulting from this were all reported as difficult experiences for these women.

In summary, then, the buying and wearing of clothes after pregnancy was reported as a major factor contributing to how the women felt about their weight at this time. A total of 16 women (43%) reported this as a factor and for all but four of these women the effect was negative resulting in their feeling the same or worse about their weight. I have argued that the significance given to clothes by the women is unsurprising given the social importance attached to women's personal appearance and the way that clothes are integral to this.

5.2(iv) Comments From Medical Professionals, Partners, And Kin

As I have discussed in the preceding chapters, there is a wide medical literature noting the health risks associated with fatness and fatness in pregnancy and thus the likelihood of fat women receiving advice about their weight and diet seems high. However, advice from medical professionals during pregnancy in this study was less common than expected (see chapter four). One possible reason for this may have been that pregnancy was not seen by some medical professionals as the most appropriate time to give advice about weight and eating. Indeed, this view is echoed in some medical literature which argues that the most appropriate time to give advice about weight and eating to fat women is before or after a pregnancy, not during it (Drife, 1986). It is possible, therefore, that medical advice about weight and eating might be more likely to occur in the period immediately after pregnancy rather than during pregnancy given that this is a period when women are in close contact with the medical profession.

Surprisingly, only a minority of women had any mention made of their weight after pregnancy. A total of eleven women (30%) reported that some mention was made of their weight by medical professionals in the period after childbirth and before the second interview. For most of these women this occurred at the six week post-natal check-up or an earlier visit to the doctor. Only four women reported mention being made of their weight during their stay in hospital. In the preceding chapter I made the distinction between 'comments' and 'advice' given by medical professionals. I defined 'comments' as statements that did not include instructions regarding weight loss and 'advice' being statements that did. Most of the women who had mention made of their weight after

childbirth received 'comments' rather than specific 'advice' regarding their weight. This was just as true for those who had mention made of their weight by medical professionals in hospital as for those who had mention made of their weight by medical professionals in the community. Only two women reported receiving specific advice rather than just comments. One of these women had become diabetic during her pregnancy and, as this was viewed as a weight-related problem, she was given specific advice about weight loss with a view to minimising her chance of becoming permanently diabetic. The other woman had no specific health problems related to her size. The reason she received advice was probably due to a particular interest in weight on the part of her G.P.. All the other women in this group received comments rather than advice and the following quotations were typical of these:

> 'All the doctors in hospital said something about my weight. Everybody I saw mentioned it. They didn't give me any advice, they just said: "You need to lose some weight, are you going to have a go?" and I says: "Yes" and they said: "Well you ought to try" and that's it. Nothing else is said'
> (Angela Downer).

> 'My doctor only said, when I stood on the scales, that my weight was too high but he never suggessted that I went on a diet or anything like that'
> (Louise Marsden).

Thus, only a minority of women had any mention made of their weight by medical professionals after pregnancy and, where mention was made, this tended to take the form of comments rather than advice.

The tendency by medical professionals to make comments rather than to give advice about weight is, I would argue, important in contributing to negative feelings about weight. Indeed, several women noted that the sorts of comments that were made to them contributed to their feeling

equally or more dissatisfied with their weight after pregnancy than before. Giving advice about weight has the *potential* to make someone feel positive about their weight in a way that comments do not. Giving advice is a positive act: it implies that someone is interested, is willing to help, and perhaps most importantly, that they believe that an improvement in a situation *can* be made. Comments, on the other hand, are of a very different nature and have much more scope for resulting in negative feelings. While comments may not necessarily be negative in themselves or in intention, because they are not backed up by a discussion about how the situation can be changed, the potential for negative feelings is much greater. In fact, all but one of the women who received comments about their weight viewed these as negative because they felt that these comments merely drew attention to their weight without offerring them any possible solutions as to how this situation could be changed. It seemed that while the women were constantly aware and dissatisfied with being fat this was an internal feeling that it was possible to cope and live with. However, the occasions when others drew attention to their weight intensified these feelings to such a point that they became much harder to cope with. Similar experiences to these have been reported by other groups who are stigmatised because of a particular physical characteristic (see Blaxter, 1976; Breakwell, 1986).

It is important briefly to put forward some possible explanations why advice regarding weight after pregnancy was so rare for this group of fat women. It is somewhat surprising that advice was given so infrequently given that the medical literature gives such an emphasis to this topic and that the period after childbirth might present an ideal

opportunity to give such advice. Furthermore, it seems likely that such advice was desired and expected by the women so it is improbable that advice-giving was under-reported in the interviews. Indeed, several women who reported that they received no comments or advice from medical professionals expressed a great deal of surprise at the lack of information and this led some to *ask* for advice. Given the paucity of medical advice given both during and after pregnancy it must be concluded that weight is not the major concern of most health professionals that the medical literature indicates. Much literature from the sociology of medicine in recent years has noted that a process of 'medicalisation' has occurred whereby more and more areas of life have become the concern of the medical profession. Part of this process of medicalisation has been seen as being the giving of life-style advice, on such topics as diet and exercise, by doctors (Conrad, 1981; Armstrong, 1983). The evidence from this research leads me to suggest that, at least in the area of weight, there is a move away from this medicalisation model to one of personal responsibility (see D.H.S.S., 1976). The Thatcher Governments of the 1980's have emphasised personal rather than state responsibility in many areas and medicine has not been excluded from this. Indeed, Edwina Currie in her period as Health Minister made many statements regarding personal responsibility for health particularly in the area of lifestyle. This trend towards personal responsibility may be a partial explanation for advice being given so rarely to the women in this study.

Lay comments and advice were more common than comments or advice from medical professionals and these too had some impact on the women's feelings about their weight. A total of 21 women (57%) received some

comments or advice from partners, kin or friends. Most commonly comments or advice came from partners and/or mothers. Unlike lay comments and advice received during pregnancy when the focus was more on diet, comments and advice after pregnancy tended to focus almost exclusively on weight. Furthermore, the prohibition on disapproving comments about weight during pregnancy seemed to be removed after pregnancy. Again, this probably indicates how pregnancy is a time when women have a social image that is not dependent on sexual attractiveness but that this image is quickly re-established after childbirth. The types of comments or advice given and their effect can be divided into four groups. First, comments that centred round some acknowledgement and approval of weight loss which contributed to the women feeling better about their weight and size. Secondly, comments or advice that offered encouragement about weight loss, either actual or potential, or about other aspects of a woman's personal appearance or personality. These led to the women having fairly positive images about their weight and appearance. Thirdly, comments about weight and size that were viewed as negative in some way which contributed to the women feeling worse about their weight and size. Fourthly, comments that were viewed as particularly derogatory and which were seen to lead directly to the women feeling worse about their weight and size.

Four women in this group of 21 women noted that the acknowledgement or approval from others about their weight loss resulted in their feeling better about their weight. In all four cases this acknowledgement and approval came from female kin (usually mothers) and friends rather than partners. Acknowledgement of weight loss was seen by the women as approval of weight loss and indeed this was probably the

case given the social stigma attached to fatness in our society. However, in some cases overt approval of weight loss, rather than just acknowledgement of weight loss, was given to the women by their mothers. The move from mothers' disapproval and 'nagging' when fat to approval and congratulations when slimmer is likely, I would argue, to leave the women in no doubt as to the social status afforded to women according to body-size. Such behaviour demonstrates that fat equals bad and slim equals good. For these women the acknowledgement and approval about weight loss that they received was an important element in enabling them to feel positive about themselves. The following quotation demonstrates these points:

> 'My mum. I'm not kidding, every time she comes here she always moans about my weight, always. And honestly this is the first time ever that she hasn't mentioned my weight and in fact she said to me: "You look good". And in fact she even told my grandmother, she said: "Oh, Katie's looking really good, she's lost ever such a lot of weight, you should see her". ... Lots of people have said to me about how much weight I've lost and they all say: "Oh, you look so well and you look so happy" and that's, like, boosted my confidence'
> (Katie Price).

A total of seven women reported receiving comments or advice that offerred encouragement about weight loss or about another aspect of their appearance. For four of these women this encouragement came from partners. For two of these, the encouragement related only to weight and for the other two it related to other aspects of their appearance. For these four women, the comments, advice and encouragement that they received were all of a positive nature which enabled them to feel fairly positive about their weight and appearance even though they may not have experienced weight loss. Two of the women who received comments from

partners, as well as the other three women in this group, also received comments or advice from their mothers. These related specifically to weight and consisted of advice and encouragement in order to aid weight loss. These too were of a positive nature which enabled the women to feel fairly good about themselves. The existence of this encouragement regarding weight from both partners and mothers and the effect it had on the women reflects the social pressure and expectation that women should be slim. This was illustrated in particular by remarks from mothers who demonstrated the social approval that can come with slimness and sexual attractiveness. The following quotations support this point:

> 'My mother said: "It's important to get your figure back and don't let yourself go and make sure you look nice and do your hair and that"'
> (Alison Norris).

> 'She [her mother] did say, at the beginning when I lost a stone and a half [10kg.], well when I told her she said: "Oh, if you lose a bit more you'll be the apple of your dad's eye again, you know"'
> (Judith Osborne).

Thus, for these women the encouragement they received from partners and mothers enabled them to feel fairly positive about their weight and appearance. This was because the encouragement that they received led to their feeling either that weight loss leading to social approval was possible, or that they had the social approval of their partners which enabled them to feel fairly good about themselves even though they were fat.

A total of eight women reported that comments about their weight contributed to their feeling worse about their weight and size. Five of these women received such comments from their partners and three from their mothers. The comments were generally of a disparaging and

negative nature and did not encompass advice about weight loss. They appeared to be comments that were not made maliciously but were observations or 'jokes' made about a woman's appearance. Again, the effect that such comments are able to have reflects the social emphasis on women's appearance and the association of slimness with sexual attractiveness. However, while the comments made to these women were seen as negative and contributed to their feeling worse about their weight, these women did have some personal resources that prevented such comments from having too severe an effect on their confidence about themselves and their appearance. Thus, the comments contributed to these women's feelings about their weight rather than caused such feelings. The following quotations illustrate this:

> 'Oh, he's [her husband] always making comments. I just ignore them. Because it took a long time for my tummy to go down after having him [the baby] he kept on saying, like, "When is the other baby going to be born?" just snide sort of comments like that. I don't like it but I just ignore him ... he just thinks he's being funny'
> (Barbara Holmes).
>
> 'She [her mother] keeps saying to me: "You do realise that when she goes to school and everything they're all going to take the mickey out of her for having such a fat mum" and things like that. I just wish she'd leave me alone because since I've had her [the baby], I've had no time to think about it . ... The only time I think about it is when she starts on about it'
> (Jenny Harris).

The final group of women (n2) noted that the comments made to them about their weight had a profound effect on their feelings about their weight. Unlike the group discussed above, these two women felt unable to protect themselves from such comments and this resulted in their feeling much worse about their weight than they otherwise might have done. For one of these women, the comments came from her partner and

for the other, from her mother. The comments were no different from those experienced by the group discussed above, the difference being in the ability to cope with such comments. It may be that increased vulnerability to negative comments regarding weight occurred as a result of general feelings of low self-worth and unhappiness that can occur after childbirth and this topic will be discussed below.

In summary, then, medical and lay comments and advice had some effect on the women's feelings about their weight after pregnancy. The medical professionals who came into contact with the women in this study tended not to discuss women's weight with them routinely. However, where this did occur they tended to make comments rather than to give specific advice. This may have contributed to the women's negative feelings about their weight and their size in a way that advice might not have done. Lay comments and advice were more common, and most frequently were made by partners and mothers. The nature of such comments or advice had an effect on the women's feelings about their weight. Negative comments tended to lead or contribute to women feeling bad about their weight and positive comments led to women feeling good about their weight. I have argued that the responses that partners and kin made to the women about their weight and the effect that such responses engendered in the women reflect the high social status afforded to slimness in our society.

5.2(v) Satisfaction With Life In General

The final area identified as important in contributing to women's feelings about their weight after pregnancy was that of their general feelings of emotional well-being and satisfaction with life in general in the first few weeks after childbirth. Pregnancy, childbirth and

motherhood have been reported as sometimes having marked detrimental effects on women's feelings of emotional well-being and contentment. Some studies have suggested that such changes are largely hormonal. However, other sociological studies have identified a number of factors relating to the birth experience, motherhood and social support that contribute to women's emotional well-being in the first few weeks after childbirth (Oakley, 1980; Ball, 1987). It is these factors identified by the sociological studies that I will concentrate on here.

One's feelings about oneself arise to a large degree from social interaction. The sorts of work that we do, the social activities that we participate in and the way we are treated by others all contribute to the way that we feel about ourselves. If an experience in one or more of these areas changes dramatically and becomes negative it is likely to have a severe effect on self-image and self-esteem. An example of this is the case of unemployment (Fagin and Little, 1984; Warr, 1987). Certainly childbirth and motherhood are experiences that bring marked changes in a woman's life even when this is not a new experience as with first-time motherhood. These changes have led some authors to call childbirth and motherhood a stressful life event as has been noted above (Oakley, 1980). Where such changes are experienced negatively it is likely that this will have a negative effect on a woman's emotional well-being. Feelings of emotional well-being and satisfaction with life in general have a significant effect on how people feel about themselves. If someone is feeling 'down', dissatisfied or unhappy about their life in general then they are unlikely to be able to feel good about themselves. In these sorts of circumstances people are likely to

have increased feelings of vulnerability regarding areas of their life that they feel dissatisfied with at the best of times. Such dissatisfactions may centre around past events, perceived failures, personality characteristics or physical appearance.

In the case of most of the women in this study, weight was a major dissatisfaction in their lives before pregnancy. It is possible, then, that feeling unhappy, 'down' or dissatisfied with life in general after childbirth might lead to some women feeling worse about their weight, or feeling increased sensitivity to it, than they had done before pregnancy. For many of the women in this study, their weight and body-size was something that caused them extreme dissatisfaction and, in some cases, distress. Feelings of unhappiness with life in general might have the result of intensifying this dissatisfaction with their weight so that it became even more difficult to cope with, resulting in their feeling much worse about their weight than they had done before. Indeed, for some women in this study this seemed to be the case. Only four women reported directly feeling worse about their weight as a result of their general feelings of poor emotional well-being. However, the data collected seemed to suggest that this may have been a factor for a much larger number of women as the following discussion will demonstrate.

There is a considerable amount of sociological literature examining the effect of childbirth and early motherhood on emotional well-being (Oakley, 1980; Welburn, 1980; Breen, 1981; Ball 1987; Martin, 1989). This literature identifies six factors as important in contributing to women's emotional well-being after pregnancy: first, the experience of childbirth and in particular the use of technology during it; secondly,

the experiences surrounding the post-natal period in hospital; thirdly, feelings of satisfaction with motherhood; fourthly, the extent of social support and the support from a partner in terms of housework and childcare; Fifthly, the existence of paid employment outside the home; and sixthly, social factors such as social class and housing. There was some evidence that these factors identified above contributed to the women's emotional well-being at the time of the second interview. Their emotional well-being, in turn, appeared to affect how they felt about their weight. I will now go on to discuss each of these factors in relation to the women in the study to illustrate this.

(1) The Experience Of Childbirth

There is a considerable amount of sociological research that has noted that the more technology and medical intervention used during childbirth the less that women feel in control of the event. This has been identified as one factor leading to post-natal depression, difficulties with relating to the baby and general feelings of dissatisfaction or poor emotional well-being in the early weeks of motherhood (Oakley, 1980: Martin, 1989). This literature has been discussed in chapter one. There has been a trend in recent years towards medical intervention in childbirth (Karpf, 1988) and this was reflected by the types of births experienced by many of the women in the study. A total of 17 women (46%) experienced a high degree of medical intervention in childbirth. Six of these women were induced, three had planned caesareans, five had unplanned, emergency caesareans and three had forceps used in the delivery of their babies. Many of the other women experienced less medical intervention during childbirth but the event was still very much a medical one. The medical nature of the

event was marked out as such by the use of analgesics and medical procedures that tend to remove control from the women and place it in the hands of the medical profession. Out of the 29 women who had 'normal' deliveries (that is, not caesareans) 17 women had episiotomies, ten women had epidurals and nine women had pethadine. Only nine of the women who had normal deliveries had gas and air only during delivery and only one woman had no pain relief at all. This woman had her baby at home, although this was not planned, and this experience stood out as a very positve one and in stark contrast to the hospital births.

In some cases it appeared that the extent to which the event of childbirth was medically managed, which was related to the extent to which women felt in control, had an effect on how the women felt about their experience of childbirth. Women who had high medical intervention births and felt it was not in their control seemed to report more negative feelings than those who had births experiences with lower medical intervention. The following quotations contrast this. The first is from a woman who had a high medical intervention birth with epidural, pethadine, episiotomy and finally delivery by forceps. The second is from a woman who had pethadine only, and this at a late stage, so that she still felt she was 'in control' of the birth. The third is from the woman who had her baby delivered at home by her husband with no medical assistance.

'I felt nothing, absolutely nothing, totally dead. I feel cheated, very cheated. It's almost like you don't give birth, you get her taken away because that's how it felt, she was taken, not given'
(Louise Marsden).

'It was wonderful, because with her [first child] I didn't experience anything, no contractions, no pushing sensations, forceps, the works. This time I did it all on my own. I mean they gave me pethadine and they gave me an

episiotomy again ... but I felt that I'd experienced everything ... Afterwards I felt it was all my hard work and not theirs'
(Katie Price).

'It was lovely. Afterwards I sat up all night just thinking about it because it was so lovely. Just me and my husband, just the two of us there. I suppose the circumstances made it different to what I would have felt in hospital but I didn't feel tired or anything and I'd had no drugs so I did, I just felt wonderful'
(Lucy Bowles).

For other women, however, it was not the extent of medical intervention that marked out a birth experience as 'good' or 'bad' but rather how such an experience was *interpreted.* This was largely to do with the expectations that the women had about childbirth. Some women had childbirth experiences that had a high degree of medical intervention and which sounded 'bad' experiences but they did not view these negatively. Other women had what appeared to be 'normal', quick deliveries which sounded relatively 'good' experiences but were ones which they viewed as negative. Thus, what marked out childbirth experiences as 'good' or 'bad' for the women in this study was not necessarily the level of medical intervention, although this was undoubtedly a factor for some of the women, but rather the way that the experience was interpreted. A total of ten women (27%) found the childbirth event a very positive experience while 14 women (38%) found it a very negative experience. The remaining 13 women (35%) felt that the childbirth event was neither very good or very bad. Certainly it seemed from the reporting of the childbirth event by the women that the experience of childbirth and the interpretation of it as 'good' or 'bad' was very important in some cases in contributing to the women's feelings about themselves and their babies in the early weeks of motherhood.

Such a finding is unsurprising given the dramatic nature of such an experience and this has been well reported in the literature (Breen, 1981).

(2) The Post-Natal Period In Hospital

All but one of the women in the study spent part of the post-natal period in hospital. The length of hospital stay ranged from one to fourteen days. The great majority of the women spent some or all of their stay in a large city hospital. Some of the women who lived in rural areas transferred from the city hospital to a small cottage hospital after a few days and completed their post-natal care there. Given the dramatic experience of childbirth that the women had recently undergone, their vulnerability as a result of this and probable physical discomfort and hormonal changes, their experience in hospital is likely to be extremely important (see Ball, 1987). Only five of the 36 women who spent some period in hospital after childbirth viewed this experience as positive. A total of 15 women viewed the experience as neither good or bad and 16 women viewed the experience as negative. Factors that were reported as contributing to the women's feelings regarding their hospital stay were the attitudes of hospital staff, anxiety about the baby's health and a desire to be home. The following quotations portray these different experiences:

> 'I hated it in hospital, I couldn't stand it. It was just awful. They got me so confused because one midwife would come in and tell me one thing and another would come in about ten minutes later and tell me something different ... I did get to feel very down but that was just because I really wanted to go home'
> (Jenny Harris).

> 'I had a great time in hospital, I really enjoyed it. We [in the ward] all got to know each other really well and we

had a really good laugh and we got on well with the nurses and that'
(Susan Crawford).

There was some evidence emerging from the data that the women who had quite negative experiences of their hospital stay appeared to have poorer feelings of emotional well-being than those with more positive experiences. This, then, may have been a factor in contributing to overall emotional well-being in the early weeks of motherhood.

(3) Satisfaction With Motherhood

Satisfaction with motherhood is a further factor identified as important in contributing to women's emotional well-being in the early weeks of motherhood. There are likely to be a number of factors that contribute to whether women feel more or less satisfied with motherhood. These may be related to a woman's expectations of motherhood and the extent to which these correspond to reality, to the behaviour of her baby or to the extent to which she feels able to adjust to the changes a new baby brings. There has been a considerable amount of research that has noted that, for many women, the experience of motherhood does not live up to their expectations (Boulton, 1983). Motherhood may not lack pleasure, joy and fulfillment but nevertheless such experiences are likely to be tempered by its more negative aspects. A total of 21 women (57%) noted that the experience of motherhood was one of ambivalence, that is, joy and fulfillment on the one hand and tiredness, loss of independence and boredom on the other. For other women, the negative aspects outweighed the positive ones: a total of five women (13%) reported feeling dissatisfied with motherhood; for eleven women (30%) the reverse was true, as they felt satisfied with motherhood.

Feelings of satisfaction, dissatisfaction or amivalence with motherhood are likely to have an effect on women's general feelings of emotional well-being at this time. Having a baby is a major event in a woman's life and her life inevitably revolves around the baby, particularly in the first few weeks of its life. Women's feelings about motherhood, then, are likely to have a big impact on how they feel about themselves given that so much of their time is spent in practising motherhood. The following quotations show the extent to which feelings about motherhood contribute to general feelings of emotional well-being. The first quotation is from a woman who felt very satisfied with motherhood, the second from a woman with ambivalent feelings and the third from a woman who felt dissatisfied:

'I'm really enjoying it. Life has changed a lot, I mean, he [her baby] comes first. Everything revolves around him but I don't miss anything that I did before. I know some mums say that they get fed-up and bored but I don't. I thoroughly enjoy it'
(Claire Whitcher).

'I feel much more trapped because, like, going out is so difficult and I don't like that feeling. Also we [herself and her partner] both feel absolutely shattered and we don't get any time together, to spend together. ... But I know that even though I moan and that, underneath I'm glowing with contentment. I feel someone special, like, when I walk down the road I think: I've got my girl and I've got my boy and they're alright and we look good'
(Sandra Crocker).

'It was different to how I thought it would be. I mean, they're [babies] so reliant on you. They rely on you for everything. It don't matter what you're doing, you've got to stop. You've got no time to yourself and I think that's what gets me down. I think that's what got me down in the first place: everything was her all the time, it wasn't me'
(Rachel Hardwick).

Thus, feelings of satisfaction or dissatisfaction with motherhood are likely to be important in contributing to general feelings of emotional well-being in the early weeks after childbirth.

(4) Social Support

There is a wide literature noting the importance of social support in affecting people's ability to cope with illness and stress (Miles, 1987). In terms of the experience of early motherhood, which as has been noted is an inherently stressful situation, social support is viewed as being important in contributing to coping and positive emotional well-being (Welburn, 1980; Ball, 1987). Unfortunately the examininations of wide social networks in the early weeks of motherhood was not a focus of this research. However, support from partners in terms of involvement with the new baby and domestic work in the home was focussed on and it is this that I will be concentrating on here. Given the high level of time and energy necessary to care for a new baby and the stress involved in this, practical support from partners with the baby and/or with domestic work is likely to be very important. A high level of support from partners in these areas will contribute to a higher degree of emotional well-being in the same way as support from wider social networks will. Indeed, this has been noted in some of the literature (Oakley, 1980).

In terms of domestic work, there was little change in involvement or responsibilities from patterns identified before pregnancy (see chapter three). While most (but not all) partners tended to take some responsibility for domestic work in the first week of the women's return home from hospital, this was short-lived. In the great majority of cases the old routine was re-established by the third week after the

woman's arrival home. This meant that in the majority of cases the women were primarily responsible for domestic work. In fact only two women noted that their partners were more involved in domestic work than they had been before pregnancy. The few exceptions to domestic work being primarily women's responsibility were some middle-class couples where the male partner often worked on shifts and so was at home during the day.

In terms of childcare, there was quite a large degree of involvement on the part of partners. There were 30 women who were living with partners who were able to participate in childcare at the time of the second interview. (Those who did not come into this group were single parents, those whose partners were incapacitated due to ill-health or who were working away from home). Of these 30 women, 16 reported that their partners were very involved with the new baby. These men were reported as doing 'everything' for and with the baby, including feeding, changing nappies and getting up at night for some feeds. A total of 14 women reported that their partners were much less involved. These men would hold or feed the baby but would do little else. No women reported that their partners were not involved at all with their baby. The level of involvement of the men with their babies that was reported is fairly typical. There has been a shift towards greater involvement by men with their children in recent years but such involvement is not always a permanent condition and generally declines as babies become older (Oakley, 1986a).

It might be assumed that the greater the degree of partners' participation in domestic work and involvement with the baby, the greater the level of emotional well-being a woman would be likely to

experience. Those women whose partners were most involved reported that they were satisfied with their partners' participation and it is likely that this contributed to their ability to cope and to feel satisfied with motherhood. However, a number of women who reported that their partners were less involved also reported that they were satisfied with this. This is probably a case of 'what is must be best' and not being able to think of alternatives to the conventional domestic roles that are based on the idea that women are primarily responsible for 'domestic' duties. For these women it is unlikely that their level of emotional well-being was as high as those who had a greater degree of support from their partners even though they may have reported that they were satisfied with this level of support. On a common-sense level it seems that a partner's greater involvement with domestic work and his baby would contribute to greater emotional well-being for a woman and, indeed, the literature points to this conclusion.

(5) Employment

For women, being in paid employment and having another role than that of being a mother and housewife have been seen in many studies as very important in terms of emotional well-being (Nathanson, 1975; Brown and Harris, 1978; Miles, 1988). It is argued that the role of mother and housewife is an isolated one that has low social status attached to it. Being in paid employment, in addition to being a mother, may be stressful but many studies have noted that this is actually less stressful than being a full-time mother/housewife (Miles, 1987). There are a number of reasons why this might be so and issues of social status, income and social contacts are likely to be very important in

this. Thus, the existence of employment outside of the home will be a factor contributing to emotional-well being for women.

The women in this study were interviewed approximately six weeks after childbirth and it was, therefore, unlikely that they would actually be in paid employment at this early stage after childbirth. However, a total of six women (16%) had actually resumed some paid employment by this stage or had made definite plans and arrangements to resume work over the following months. A further eight women (22%) planned to find some employment within the next year although they had made no firm arrangements as to what or where this might be. Most of the women who had found, or planned to find, paid employment noted that this was for financial reasons. However, in addition to this, they also noted that they felt a personal 'need' to work because they wanted to continue their careers or because they would be bored at home and felt that they needed 'something else' in their lives. The majority of the women (n23, 62%) had no plans for employment and most of these noted that they would probably not become employed until their child(ren) had started school. Most of these women adhered to the dominant ideology that a mother's place is with her child (Oakley, 1986a). Thus, it was not that all these women did not 'want' to work or did not experience frustrations with being mothers/housewives. While some women were obviously satisfied with being at home, others felt more that it was not 'right' to work because they felt their place was with their child. The following quotations demonstrate these perspectives. The first two are from women who had no plans to find employment and they both refer to the dominant view that women should stay at home with their children: the first appears quite satisfied with this but the second less so. The

third quotation is from a woman who notes that her 'need' to go to work overrides this.

> 'I might get a job when the children are at school but not before then. I think women should stay at home when they've got young children because otherwise you miss the upbringing of them. You have to make sure you're there when you're needed. ... I really enjoy being at home with the baby ... I haven't got bored at the moment. I keep generally busy so I can't see myself feeling like that'
> (Claire Whitcher).
>
> 'Now I'm thinking that I don't think I could go back just for personal fulfillment until the kids are four or five. I don't think I could do anything until then. I'm even more determined to do something but I'm less determined to do it so quickly. I just don't think it's right to wish their lives away'
> (Sandra Crocker).
>
> 'When I first had her I didn't want to go back [to work] at all. I didn't want to leave her, sort of thing. Now I've been in the house for seven weeks I feel a bit different. ... I just felt I was going to be in this house forever. You feel that the whole of your life is looking after the baby and housework and that's it. ... So I wouldn't want not to go back to work because I'd just get bored in the end and I don't think it would be very good for me and I certainly don't think it would be very good for her'
> (Josie Robbins).

The importance of paid employment seemed to vary according to women's satisfaction with the roles of mother and housewife. However, for women who experienced some dissatisfaction with these roles, the feeling of being free to seek paid employment was important in terms of emotional well-being.

(6) Social factors

The final area of importance in examining emotional well-being is that of social factors such as social class, housing and age. A variety of social factors have been identified in various studies as operating against individuals making their experience of an event, and the extent to which they can cope with it, more negative than someone without such

'handicaps'. Such factors are likely to affect emotional well-being (Brown and Harris, 1978). Some of the women in this study had social factors that were likely to stack the odds against them in terms of their ability to cope with an experience like early motherhood. The majority of the women (n21) were working-class and many of these lived in council accommodation much of which was in poor, run-down areas of the city. In addition, some of the women were single parents (n3), some cohabited as a result of the pregnancy (n2), some were under the age of 21 (n5) and some had experienced three or more pregnancies before the birth of this child (n6). Women experiencing such difficulties in their lives are likely to find the first weeks of motherhood more difficult and therefore to have a lower level of emotional well-being than women without such difficulties.

In summary, then, six factors have been identified from the existing literature as important in contributing to emotional well-being in the early weeks of motherhood: the experience of childbirth; the experience of the post-natal period in hospital; satisfaction with motherhood; social support; employment; and a variety of social factors. These factors have been examined in order to support the argument that women's emotional well-being at this time, which may be largely related to these factors, is important in contributing to how they feel about their weight. I have argued that those women who have a high level of emotional well-being as a result of positive feelings and experiences surrounding childbirth and early motherhood are likely to feel positive about themselves and consequently about their weight. Women with more negative experiences are likely to feel much less positive about themselves and, consequently, about their weight.

5.2(vi)The Association Between Emotional Well-Being And Feelings About Weight

As I have noted above, all people get a feeling of their own self-worth as a result of, among other things, the things that they do in their lives. If they get no enjoyment, satisfaction or value from the things that they do then they are likely to feel negatively about themselves. Women who have had negative experiences of childbirth and early motherhood, who have low levels of support from others and who have no alternative sources of gratification outside of their role of mother are likely to feel very negatively about themselves in much the same way as has been described for unemployed people. Indeed, this has been highlighted in the literature on motherhood (Welburn, 1980). The extent to which a woman feels negatively about herself as a result of these experiences may be dependent on first, the number of negative experiences she has and secondly, the degree to which the experiences are seen as negative. For example, women with a negative birth experience but positive experiences of the other factors identified might have a high emotional well-being in the early weeks of motherhood because the positive aspects outweigh the negative ones experienced at the birth. On the other hand, women with a greater number of negative experiences are less likely to have a high level of emotional well-being. However, women who have particularly negative experiences in only one area may end up with a low level of emotional well-being because the one negative experience has been so bad that other positive experiences cannot compensate for this. The relationship between the experiences outlined above and the end result of emotional well-being is obviously a complex one. The following four case studies will help to

clarify and illustrate the nature of the relationship between these factors. Following on from these I will go on to discuss the relationship between emotional well-being and the women's feelings about their weight.

The following four case studies illustrate how particular experiences in the areas identified above led to a positive or negative level of emotional well-being in the early weeks of motherhood. The first two examples are of women who had a low level of emotional well-being in the early weeks of motherhood and the second two are of women who had a high level of emotional well-being:

Case Study 1: Louise Marsden

Louise felt that her experience of childbirth was particularly traumatic and she was very disappointed by it. She had a long labour which included the use of an epidural and forceps in delivery and as a consequence she felt the birth was very little to do with her. The period she spent in hospital was an equally negative experience: Louise's baby was three weeks premature and jaundiced and so spent seven days in Special Care and was only brought to Louise for feeding. All of this resulted in Louise having great difficulty in relating to her baby and her satisfaction with motherhood once she came home continued to be very low. She had no plans for employment. Her husband was very supportive initially but he broke his wrist when the baby was three weeks old and so he was unable to give any practical support at the time of the second interview. The family were middle-class and there were no social factors making her experiences of childbirth and motherhood particularly difficult.

Case Study 2: Rebecca Young

Rebecca felt that her experience of childbirth was particularly negative. She had a long labour and had gas and air, pethadine and an epidural. She also had a lot of stitches as the baby was very big (4.75kg.). Her experience in hospital was negative too. The baby was in Special Care for two days and she found the whole experience of being in hospital very depressing. She felt very anxious about the baby and about her ability to cope and this meant that her satisfaction with motherhood was quite low. She had no plans for employment. Her partner was quite supportive but because of factors related to her social situation she did not always find this an asset. The social factors that made her experiences particularly difficult were her age (20) and the fact that the pregnancy was unplanned. Rebecca lived with her parents until the baby was two weeks old when she moved into temporary rented accommodation with her boyfriend and she experienced a number of difficulties with this new situation in respect of her relationship with her boyfriend. In addition the couple had to manage on a very low income with little possibility of financial support from parents because of their own lack of resources.

Case Study 3: Carol Smith

Carol had quite a negative experience of childbirth in that she was induced, given an epidural and finally ended up with an emergency caesarean under epidural anaesthetic. However the negative aspects of this were outweighed by a very positive experience in hospital after the baby was born and very high feelings of satisfaction and enjoyment with the baby and motherhood. Carol's partner was very supportive in terms of both domestic work and childcare. His job involved shift work and

because he was often at home during the day he was able to participate in a way that other partners were not. Carol had no plans for employment although before the baby's birth she had intended to return to work. She changed her mind about this because she found she enjoyed motherhood too much to return to work. The couple were middle-class and there were no social factors making their experience of childbirth and motherhood particularly difficult.

Case Study 4: Teresa Browne

Teresa felt that her experience of childbirth was what she had expected it to be. She had quite a long labour and had pethadine. However, she did not view it as a negative experience. She felt 'bored' in hospital and eager to get home but again this was not viewed particularly negatively. She felt quite satisfied with motherhood and had no major worries or anxieties. She resumed work (as an agency nurse about three days a week) when the baby was five weeks old. Her partner was not very supportive in practical terms with either the baby or housework but Teresa noted that she was satisfied with this as she preferred to do things herself. There were no social factors making their experience of childbirth and motherhood particularly difficult.

These four examples, then, illustrate how the various experiences encompassed in childbirth and early motherhood, and how these are interpreted by women, can have an impact on emotional well-being.

I have argued that levels of emotional well-being had an effect on how the women felt about their weight. As I have noted above, the majority of these women felt dissatisfied and unhappy about their weight before pregnancy. Many had quite negative views about themselves in terms of their appearance because they felt they did not look as they

'should'. Women who feel this way can raise their self-esteem by finding another area of their lives that they can feel good about. Some fat women tend to do this by developing a 'jolly' personality or through achievement at work or at another activity that they feel that they enjoy or are good at. This enables them to focus on something other than their appearance in assessing their self-worth. However, failure in another area (other than appearance) is, in such cases, likely to be experienced very badly and to put even more focus on the original problem, that of size. This is, I would argue, what happened to some women in this study. Their experiences of motherhood and the events surrounding it were important to their self-image and indeed the same is likely to be true for all women whatever their size. However, for these fat women, where the experiences were particularly negative, this resulted in their feeling even worse about their size than they had done before. Not only did those who had negative experiences feel worse about their size but they also felt powerless to do anything about it. Women with more positive experiences and consequently a more positive outlook not only felt better about their size but also expressed more positive attitudes towards dieting and trying to change. The following quotations illustrate this link between emotional well-being and negative attitudes to weight and size. The first two are from women who felt very negatively about motherhood and their weight and the third from a woman who felt much more positively:

> 'I get so fed-up. I mean it's a multitude of things. It's your weight, you can't get into any of your clothes, you're fed-up, the baby keeps crying, all you seem to do is change nappies all day, he [her partner] comes home from work and all I've got to talk about is what she's [the baby] done and I sound like an old fishwife. ... I mean I got very

depressed, there were several things that worried me and one of those was my weight'
(Rachel Hardwick)

I feel really down, it's awful really the things you get down about. The kids are alright and everything, I should be feeling on top of the moon really. But I can't get out so much and I miss seeing people plus I find it very hard work with the kids and my weight bothers me. I wish I could lose a bit'
(Liz Roberts).

'I'm quite pleased about my weight but it's not something I've given a great deal of thought to at the moment. I mean I shall go to WeightWatchers and try to lose it but it's not bothering me at the moment. There's too many other things to think of. That's the least of my worries at the moment'
(Barbara Holmes).

Thus, to summarise, the experience of childbirth and motherhood appeared to have an impact on some women's feelings about their size. Some women who experienced childbirth and motherhood negatively ended up feeling worse about their weight than they had done before pregnancy and some women who experienced these positively ended up feeling better about their weight after pregnancy.

This concludes this section looking at the various factors that were identified by the women as contributing to their feelings regarding their weight after pregnancy. Five factors have been identified: the amount of weight lost or gained; a change in body shape or appearance as a result of pregnancy; the buying and wearing of clothes; comments or advice from lay people and the medical profession; and, emotional well-being.

## 5.3 EXPERIENCES REGARDING WEIGHT AND EATING

At the time of the second interview, a comparison of the women's post-pregnancy and pre-pregnancy weights showed that there was some variation between the women regarding the extent to which they had returned to their pre-pregnancy weights. As I have noted above, 16 women (43%) weighed within 6kg. of their pre-pregnancy weight, seven women (19%) weighed in excess of 7kg. less than they had done before pregnancy and 14 women (38%) weighed in excess of 7kg. more than they had done before pregnancy. The maximum weight loss and the maximum weight gain was 35kg..

A major explanatory factor regarding the different levels of weight loss after childbirth for these women was obviously the fact that weight gains during pregnancy varied greatly. As has been noted above, some women lost weight or had very low weight gains during pregnancy while others had very high weight gains. Those with low weight gains were more likely to lose weight overall after pregnancy or to reach or come closer to their pre-pregnancy weight quicker than those with high weight gains. Physiologically, it is improbable that a return to pre-pregnancy weight will be achieved by six weeks after childbirth unless weight gain has been low as much of the medical literature notes (Greene et al, 1988). However, many women may expect such an outcome.

A comparison between post- and pre-pregnancy weight seemed to be very important to many of the women in terms of contributing to their feelings about their weight after pregnancy. However, regardless of whether weight gain or weight loss had occurred after pregnancy, the majority of the women still felt dissatisfied with their weight just as they had done before pregnancy. Evidence for this is the fact that 34

women (92%) were actually dieting or planning to diet. While physiological factors may have made weight loss unlikely or difficult at this point there were a number of factors relating to eating, identified both by the women and by myself from the data, that appeared to increase these difficulties. These factors are in addition to those discussed in chapter three that were identified as making initial and long-term weight loss difficult for fat women and relate specifically to the situation of early motherhood. The factors identified were: breast-feeding; comfort-eating; and, changes in the practical and ideological organisation of food and eating. It is these factors that make immediate and long-term weight loss difficult at this particular stage of the life cycle that I will now go on to discuss.

5.3(i) Breast-feeding

There has been a strong shift in recent years towards the advocation of breast-feeding rather than bottle-feeding of infants because of the physical and emotional advantages to the baby and mother that this is seen to have (Boyd and Sellars, 1982; Oakley, 1986a). These advantages are stressed in the ante-natal literature given to all pregnant women. In addition, breast-feeding is particularly advantageous to fat women because it is associated with a greater degree of maternal weight loss. This association has been fairly widely reported in the medical literature (Greene et al, 1988) and is referred to, albeit as a side-benefit of secondary importance to benefits to the baby, in the popular ante-natal literature. The dual benefits to both mother and baby of breast-feeding may mean that for fat women in particular, breast-feeding is an option that holds considerable advantages. The possibility of weight loss as a result of breast-

feeding is certainly likely to be an additional incentive encouraging fat women to breast-feed.

The majority of women in the study attempted breast-feeding initially. However, many of these felt that, for various reasons, they could not continue with it and gave up within a month. This is a fairly common occurence and has been noted in other studies (Boyd and Sellars, 1982). However, 14 women (38%) breast-fed for more than four weeks and twelve of these women were still breast-feeding by the time of the second interview. Many of these women who persevered with breast-feeding noted that one of the major reasons for wanting to breast-feed in the first place was the likelihood that it would help them to lose weight. However, weight loss associated with breast-feeding is inevitably slow and the extent of weight loss is unclear until breast-feeding ceases which is often when the baby is between six to nine months old (Bradford, 1988). Some of the women expressed some frustration at the slow nature of this weight loss.

In addition to the frustration that the slow nature of weight loss associated with breast-feeding brings for fat women is the problem that breast-feeding demands the consumption of a high energy and high protein diet. Breast-feeding women are advised in the ante-natal literature to drink more liquids and to eat 'healthily' and adequately during this period, following a diet similar to that consumed during pregnancy which contains a higher number of calories than a 'normal' person would need. It is noted in this literature that breast-feeding women may find that they are hungrier than usual and they are strongly advised not to go on weight reducing diets until they stop breast-feeding. The necessity and desire to eat more and the prohibition on

dieting during breast-feeding, then, may be additional factors causing anxiety for fat women regarding their weight. A ban on dieting and a license to eat more while breast-feeding may act as factors leading to greater weight gain. Even where an increase in consumption during breast-feeding does not result in weight gain it is likely that this practice may feel as though it will have that result, thus leading to increased anxiety for fat women about their size.

A number of the women who were still breast-feeding by the second interview noted that they had changed their diet. For some women this meant the consumption of what they saw as a more 'healthy' diet which included the consumption of particular foods, such as fruit and vegetables, and the consumption of regular meals. These women did not feel that they would gain weight as a result of breast-feeding and expressed satisfaction that their diet had improved nutritionally even though this was done primarily for the sake of their baby. Others, however, noted that they felt very hungry and needed to eat large amounts to keep feelings of hunger at bay. They felt that they were eating too much and were concerned about weight gain and how they would manage to lose weight after they stopped breast-feeding. Some women did not experience feelings of intense hunger but nevertheless felt that the amount of food that was necessary for them to consume in order to continue breast-feeding was too much and would result in weight gain. Although, as I noted, breast-feeding women are advised not to diet, eight of the 14 women who breast-fed their babies were or had been dieting or trying to restrict food intake in some way. That just over half of the women were dieting while breast-feeding, even though medical advice counselled against this, probably demonstrates the extent of the

anxiety regarding their weight that these fat women felt. The following two quotations show how breast-feeding can lead to greater consumption, and possibly greater weight gain, and the anxieties that some of the women had about this. The first is from a woman who noted extreme feelings of hunger and the second from a woman who, although she was on a weight reducing diet set by WeightWatchers for breast-feeding mothers, still felt that she was eating far too much to ever lose weight.

> 'I'm always hungry. I don't know why because I eat well but I'm always hungry. I do try to resist as much as I can but some-times I feel I've just got to have something' (Amanda Spelling).

> 'I just feel I'm eating too much but it's what they [WeightWatchers] tell you to eat. I've got a massive big plateful at lunch time and a massive big plateful in the evening and I think: how the hell am I going to lose weight eating all this? ... But because I'm breast-feeding I've got to have all these extra calories'
> (Claire Whitcher).

For some of the women, then, increased consumption during breast-feeding, either as the result of a desire or necessity for food, coupled with a ban on dieting, made losing weight initially, and in the longer term, very difficult.

5.3(ii) Eating As A Response To Stress

In the two preceding chapters I have discussed stress and its links with eating and overeating and I noted that the majority of women in this study used food to help them to cope with stress to some degree. There is some consensus in the literature that motherhood is a situation that is inherently stressful (Oakley, 1980; Welburn, 1980; Price, 1988). Indeed, as I have noted above, a number of the women had negative experiences of childbirth and early motherhood which resulted in their having low levels of emotional well-being at the time of the second

interviews. For these women childbirth and early motherhood can be seen as particularly stressful experiences. Using the self-reporting of the women in the categories of childbirth experience, post-natal experience in hospital, satisfaction with motherhood and negative social factors that were discussed above, eight women (22%) can be categorised as experiencing high levels of stress in that they reported negative experiences in at least three out of the four categories. A further twelve women (32%) had quite high levels of stress in that they reported negative experiences in two out of the four categories. Examples of these negative experiences have been given above in the discussion on emotional well-being and it is, therefore, unnecessary to give further illustrations of these here.

Taking these two groups together as being the women who experienced childbirth and early motherhood as most stressful, there was some evidence that a number of women from these groups appeared to use food as a way of coping with this. Similar findings have been noted in other research (Charles and Kerr, 1988). This was not so for all the women in these two groups: some had a positive attitude to dieting and weight loss and did not indulge in comfort eating. For these women other factors may have been at work enabling them to cope. Neverthelss, ten of the 20 women in these two groups did report using food to help them to cope or for comfort in some way. Many of these women noted that they ate when they felt unhappy and that this was precisely how they felt as a result of their negative experiences of motherhood. The following quotation demonstrates this:

> 'Of course the problem is that when you get fed-up you want to eat and where I've been fed-up, I've just wanted to eat all the time. I mean it's lots of things: there's a pile of ironing, the washing basket's full, there's dust

> everywhere, the hoover hasn't been out for days, the baby's crying, I haven't been out and my husband's getting on my nerves. I just feel sometimes that I've had a gutful' (Rachel Hardwick).

Other women experienced motherhood as less of a stressful life event but nevertheless as an experience that brought changes in their lives which were often viewed as stressful to some degree. The constant routine of changing nappies, feeding and pacifying a crying baby both day and night as well as the loss of independence and the social isolation that often accompanies early motherhood were identified as sources of stress. Any one, or a combination, of these experiences might lead some women to turn to food for comfort and support.

In addition to the stresses associated with motherhood which may encourage women to turn to food, the accessibility that women have to food at this point in their life cycle is also important (Charles and Kerr, 1988). During early motherhood, and particularly during the first few weeks after childbirth, most women spend the majority of their time in their homes where there is open access to food. Given the stressful nature of their lives at this time the fact that food is readily available may make it more likely that they will turn to food for comfort or support. Being primarily responsible, as most women are, for the buying, cooking and serving of food may also encourage overeating. Food and nurturance are central foci of women's lives, particularly at this stage of their life cycle, and the amount of time spent both thinking about food and being in contact with it may mean that they are predisposed to eat for comfort. This may be particularly so for this group of fat women given that the majority of them reported that they ate for comfort or when they were bored, lonely or fed-up.

A number of women reported that they did use food for comfort during the early weeks of motherhood. It seemed that the accessibility of food and the time spent in contact with food in some way made the likelihood of this greater. The following quotations illustrate this. The first two are from women who noted that they tended to 'pick' at food between meals when they got bored and the third quotation is from a woman who noted that she ate more for comfort.

> 'Sometimes when she's [the baby] asleep, I think to myself: oh please wake up because I'm really bored. I really want her to wake up and then when she doesn't wake up I think to myself: I'll go and have a packet of crisps or something ... I tend to eat between meals in the morning but not in the afternoon because she's usually awake then'
> (Jenny Harris).

> 'Really since I've had him [the baby] I've been worse for eating than before. ... I think my downfall is sweets. It's in the evenings really if I'm here on my own or if my husband's doing something and I've got nothing to do. It's just picking at things really'
> (Lucy Bowles).

> 'I've been eating a lot, a lot in between times. The other day I bought one of those almond rings and I sat and ate half of that. Then I had half an hour and I went up to the shop and bought a big packet of biscuits and I don't know why I did that. I really don't know. I think it was a case of: oh, I feel sorry for myself, I think I'm going to buy some food. ... I suppose being at home all day makes it worse ... if I haven't got the stuff at home I just go up the shop and get it'
> (Brenda Gray).

Many of the women in this study, then, appeared to experience early motherhood as stressful to some degree. Some of these women turned to food as a source of comfort and support in the face of the anxiety or boredom caused by these experiences. The availability and accessibility of food in the home and women's close contact with food and nurturance appeared to account in part for the women using food in this way. Such

behaviour may be more common among a group of fat women given that a pattern of comfort-eating may have already been established as was the case for this group. Nevertheless slimmer women in this situation may be likely to use food in the same way although probably with less serious results in terms of their feelings about their weight. For the women in this study, using food in this way would be likely to mean that both initial and long-term weight loss would be improbable unless their situation changed to such a degree that they no longer felt the necessity to use food in this way. Eating in response to stress, then, may have been a factor in prohibiting weight loss for some of the women in this study.

5.3(iii) The Practical And Ideological Organisation Of Food And Eating

In the preceding two chapters I have noted how the practical and ideological organisation of food and eating determines what food women consume in households and where, when and how it is eaten. I noted that these practices often contribute to women becoming fat in the first place and make losing weight in the long term difficult. Before pregnancy, practical constraints, such as time and money, and ideological constraints, such as the privileging of male partners in terms of food consumption, determined the types of food that the women in this study ate. The major changes that occurred in food and eating practices during pregnancy was that many of the women tended to cook 'proper' meals rather than the 'convenience'-type meals that had often been the norm before pregnancy and that they did not subordinate their own food wants so completely as they had done before pregnancy.

Twenty-three women (62%) noted that changes had occurred in the practical and/or ideological organisation of food and eating in the early weeks of motherhood from those of before and during pregnancy. The major change reported by all these women was a lack of time to prepare, cook and eat food. For many of the women this resulted in a sharp fall in the quality of their diet from that of before pregnancy when many of them had made great efforts to eat regular meals and 'healthy' foods. The eating practices of the women in the early weeks of motherhood also marked a change from those of before pregnancy. While many women reported that their food consumption was determined by their employment and consequent lack of time to cook 'proper' meals before pregnancy, the results were even more dramatic in terms of quality and quantity of diet for some women after pregnancy. A large proportion of women noted that they missed meals altogether or lived on cold 'snack'-type foods during the day. Some women, especially those who had other pre-school age children, reported that they went without food altogether during the day because they had 'no time' to eat. The following quotations illustrate the impact that lack of time had on many of these women's diets:

> 'Right now I really don't have the chance to, like, grab a sandwich or anything because I'm constantly doing something. I just maybe grab a glass of juice or drink plenty of water'
> (Sarah Wells).

> 'I miss breakfast frequently. Sometimes I miss lunch, but not often. But it's the evening meal if Mike's home that we never miss'
> (Fiona Tindall).

> 'The difficult thing now is eating the meals, eating regularly. We always eat in the evening and I get breakfast in but by the time tea time comes I scoff at tea because I haven't had nothing at dinner time. It's getting my dinner in really because by the time I've finished the

> bottles, by the time I've fed her, then dinner time's over and done with. So then what happens is that normally about three or four o'clock, which is only about half an hour before tea I'll scoff whatever I can get hold of and then eat tea'
> (Mary Thompson).

The change in the practical organisation of food and eating caused by time constraints also reflects issues concerning the ideological organisation of food and eating. I noted in chapter three that the ideology that surrounds food and eating practices in the home is a familial ideology that reflects patriarchal power relations. This is so because the ideology reflects men's high status in relation to women and the notion that the nuclear family is the most important domestic unit in society (Charles and Kerr, 1988). The majority of women who reported that constraints of time led to their missing meals did not include in this the evening meal. Indeed, the last two quotations above illustrate this, as both note that the meals missed were never the evening meal. Thus, the meals that were missed or substituted by snacks were those that were eaten during the day and either alone or with children. These meals were breakfast and lunch and such meals, as was noted in chapter three, do not have the high status of a 'proper' meal in that the male partner is not present during their consumption (Kerr and Charles, 1986). Thus, the missing or substituting of these meals reflects the ideology that men have high status and that women have low status. The women felt that it was acceptable for them to miss out on food because they did not have time to prepare or eat it. However, they did not, in general, apply this principle to their partners and the preparation of the main meal of the day.

In addition to the prioritising of the main meal of the day, sometimes to the exclusion of other meals, the ideology surrounding food and eating was reflected by other practices at this time. Some women noted that having a baby made them feel that they had become a 'proper' family. This view was not only expressed by women with a first baby. Indeed, some women with a second child expressed this notion of feeling a 'proper' family even more strongly than those with a first child. They noted that with one child they had still felt that they were primarily a couple and that the child fitted in around them. However, they felt that having a second child changed their status from 'a couple plus child' to a 'family'. One of the results of this attitude was that particular sorts of eating practices and behaviour were seen as appropriate. In many cases these marked a change from the situation both before and during pregnancy. It seemed that some of the women felt that 'proper' families should have 'proper' meals. This was apparent both in terms of the types of food that some women reported that they were eating at mealtimes and in the way that these mealtimes were conducted. Some women noted that they wanted the family to eat 'healthily' now that they were a 'proper' family and this resulted in a change in diet to what they viewed as more 'healthy' foods. In addition, some women reported that they ate their main meal of the day at the table 'as a family' whereas before they may have eaten it on a tray in front of the television (Charles and Kerr, 1988). The following quotation illustrates these changes in diet that occurred as a result of feelings of becoming a 'proper' family.

> 'Because she's [her first child] beginning to feed herself now, she likes to sit in her high chair, so we make a conscious effort every day now to sit down at the table and eat with her and I will do a proper meal. That's a

> conscious effort to eat properly, not because of my weight ... it's more because I want to sit down as a family and get her to eat properly. ... I think it's because it's the family now, that's the main reason. Because she's eating better now and even he [the baby] sits in his chair at the table. So it is because it's becoming more of a family' (Katie Price).

The two changes in the practical and ideological organisation of food and eating identified as occurring at this time were both factors that may have made initial and long-term weight loss difficult for some women. In terms of initial weight loss, the practical constraint of a lack of time to prepare and eat adequate daytime meals was likely to have a detrimental effect on the women's weight. It might be assumed that an extreme reduction in food intake so that one or two daytime meals were being missed, and were not made up with other foods, would result in the overall weight loss that many of the women desired. Indeed, some of the women noted that this might be a side effect of the lack of time to prepare and eat food. It is not clear whether this was the case or not but there is some evidence that cutting out food in this drastic way does *not* have the desired effect of weight loss. There is a considerable amount of literature, discussed in chapter one, that notes that cutting down on food in this extreme way has the effect of slowing down the metabolic rate and making weight loss unlikely. It is noted that the best way to lose weight is to eat regular low calorie meals because this has the effect of speeding up metabolism and thus making weight loss more likely (Wooley and Wooley, 1979; Bradford, 1988). In addition, reducing food intake in a drastic way may have a detrimental effect on health. The fact that the women who did reduce their food intake drastically in this way noted that a side-benefit might be losing

weight and did not note the detrimental effect that this might have on their health is an illustration of the significance that weight loss held for them.

Additionally, the practical constraint of time which caused some women to substitute snacks for daytime meals may have led to weight gain. Sandwiches, cakes, biscuits and crisps were frequently reported as foods that were eaten in place of daytime meals. Frequently the women noted that they suddenly realised that they were very hungry and had missed one or two meals because they had been so busy. On such occasions they wanted to eat something quickly that would take no time to prepare and which could be eaten without having to interrupt what they were doing. The types of foods listed above were ideal for this situation. The result of replacing meals with these convenience-type snacks was likely to be weight-gain, especially if these foods were eaten in large amounts, because all these foods are high in carbohydrates. Indeed, some of the women recognised this but felt that they could do nothing about it because of the constraint of time. The following example illustrates this:

> 'I've been living off just sandwiches and I said to him [her partner] "I'm never going to get thin". Well, I don't expect to get thin but I want to get back to what I was before and I won't if I keep stuffing sandwiches because I haven't got time to cook properly'
> (Susan Hartwell).

In respect of longer-term weight loss the effect of moves to 'proper' meals and mealtimes is likely to be important. I noted above that a number of women felt that having a baby marked a new phase in their life and that some women reacted to this by making new attempts to become slim. As I have noted, the great majority of women were dieting

to some degree or had some sort of diet planned by the time of the second interview. However, the move towards 'proper' meals and mealtimes were likely to make such attempts quite difficult. Of the 26 women who had already started dieting, the majority were trying to do this by cutting down on the amount of food that they ate at mealtimes. Only four women reported being on specific diets, such as a WeightWatchers diet, which necessitated their eating particular sorts of meals that were likely to be different to the rest of the family. This is not surprising given the difficulties for women in participating in such diets because of the ideology surrounding 'family' mealtimes which, as I have noted above, became particularly dominant for some women after the birth of their baby (Kerr and Charles, 1986). Furthermore, on a practical level there are likely to be a number of difficulties, such as the time necessary to prepare two different meals, which militate against the following of such a diet for very long at this time. However, even in cases where women attempted to lose weight by cutting down on the amount that they ate at mealtimes, the ideology of 'family' mealtimes was likely to make this difficult. I noted in chapter three that the prioritising of partners' food preferences and the social significance of mealtimes, which seemed to be heightened at this time of early motherhood, were important factors that made dieting difficult and these arguments are relevant here. The greater tendency to cook 'healthy' food at this time may have negated some of the propensity to weight gain associated with the ideology surrounding family mealtimes. Nevertheless this ideology may still have made dieting attempts quite difficult for some of these women.

This concludes the section looking at the experiences of the women regarding weight and eating after childbirth and the factors that were seen as important in making initial and long-term weight loss difficult. The factors identified were: weight retention or changes in diet as a result of breast-feeding; eating as a response to stress associated with early motherhood; and, changes in the practical and/or ideological organisation of food and eating.

## 5.4 CONCLUSION

In chapter three I noted that the majority of women in this study were dissatisfied with their weight to some degree before pregnancy. I argued that the definition of women in terms of their physical (sexual) attractiveness, a central tenet of which is slimness, was a major cause of this dissatisfaction. In addition I noted that women's social roles, because of their inherently stressful nature or through the practical or ideological involvement women have with food and eating, made it easy for many of these women to become fat in the first place and made it difficult for them to lose weight in the long term. In chapter four some change was noted for many women from the feelings and experiences regarding weight and eating before pregnancy to those of during pregnancy. In terms of feelings about weight, some women reported feeling better about their weight during pregnancy and some women reported feeling worse. I argued that one of the factors in this change in feelings was the change in the social image of women during pregnancy. A change in eating practices occurred for some women during pregnancy as a result of these and other emotional, practical and ideological changes brought about by pregnancy.

In this chapter I have examined the women's feelings and experiences regarding weight and eating after pregnancy. The great majority of women reported feeling dissatisfied with their weight after pregnancy. In fact the numbers reporting this were even greater than before pregnancy. There was a change in some cases in the *degree* of dissatisfaction. Most of the women felt equally or more dissatisfied about their weight after pregnancy than they had before pregnancy and only a minority reported feeling less dissatisfied. However, even in cases where women reported feeling less dissatisfied all but two women reported that they still felt dissatisfied overall with their weight. I have argued that one of the central reasons why most of the women felt dissatisfied with their weight after pregnancy, and why for many women there was an increase in dissatisfaction, was because after pregnancy women are once again defined in terms of their physical attractiveness. The physical changes brought about by pregnancy made it even more difficult than before pregnancy for many of the women in this study to view themselves as physically attractive because they felt that after pregnancy they conformed even less to the ideal of feminine attractiveness in terms of weight, size or shape. In addition, the emotional and practical upheavals that accompany the early weeks of motherhood led to some women feeling dissatisfied with life in general which resulted in their focussing some of their negative feelings on their weight which increased their dissatisfaction in this area. In the early weeks of motherhood there was also a reversion back to many of the eating practices of before pregnancy which, as I have noted above, made initial and long-term weight loss difficult. These difficulties were compounded by some additional constraints in terms of diet. These

constraints were linked to the practical, emotional and ideological difficulties associated with the early weeks of motherhood.

In the next chapter I will go on to classify and analyse in detail the changes relating to the women's feelings and experiences regarding their weight before, during and after pregnancy. Additionally, I will discuss the implications that arise from this for fat women, the medical profession, and society.

# CHAPTER SIX: ANALYSIS OF THE RESULTS AND DISCUSSION

## 6.1 FEELINGS ABOUT WEIGHT AND EXPERIENCES REGARDING EATING: CLASSIFICATIONS

In this chapter I intend to classify and analyse the movements of the women as they passed through the stages of pre-, during and post-pregnancy in terms of the two major aspects of the research: feelings about weight and experiences regarding eating. In addition, I intend to classify post-pregnancy outcomes regarding weight and eating and to discuss possible longer-term outcomes and the reasons why such outcomes may occur. Finally, I will discuss whether there might be any scope for different outcomes for fat women regarding either feelings about weight or experiences regarding eating.

To examine the movements of the women in terms of their feelings about their weight and their experiences regarding their eating as they passed through the stages of pre-, during and post-pregnancy, I have constructed a typology containing four categories (or boxes) for each of the three periods that I have examined. The four boxes were constructed using two elements, feelings about weight and experiences regarding eating, because, as I have noted above, together these constitute the key focus of this research. All the women can be allocated to one box according to their feelings and experiences regarding weight and eating before, during and after pregnancy.

Before going on to set out these typologies it is necessary to clarify and define how the typology was constructed and how the women were allocated to their positions within it. Each of the four boxes was constructed to represent a particular state regarding feelings about

weight and experiences regarding eating and it was intended that all the women should be able to be allocated to one of the boxes for each of the three periods (before, during and after pregnancy) under study. In terms of feelings about weight, the states represented by the boxes were 'positive feelings about weight' and 'negative feelings about weight'. 'Positive feelings about weight' was defined as being when women reported an acceptance of their weight and 'negative feelings about weight' was defined as being when women reported non-acceptance and dissatisfaction about their weight and a desire to be thinner. In terms of experiences of eating the states represented by the boxes were 'controlled eating' and 'uncontrolled eating'. 'Controlled eating' was defined as being when women reported eating behaviour that fitted in with the following general pattern: eating regular meals and not 'picking' at foods in between meals; trying to eat foods viewed as 'good' and trying to avoid foods viewed as 'bad'; and, dieting on a consistent basis. Conversely, 'uncontrolled eating' was defined as being when women reported eating behaviour that fitted in with the following general pattern: eating as a response to stress, emotions or experiences; repeated 'picking' of snack-type foods; eating foods viewed as 'bad'; and repeated unsuccessful attempts at dieting. The four boxes, then, each represents a particular state regarding feelings about weight and experiences regarding eating, feelings about weight being represented on the vertical axis and experiences regarding eating being represented on the horizontal axis. Thus as the typologies in Tables 16, 17 and 18 show, box A represents positive feelings about weight combined with uncontrolled eating; box B represents positive feelings about weight combined with controlled eating; box C represents negative

feelings about weight combined with uncontrolled eating and box D represents negative feelings about weight combined with controlled eating.

Allocating women to the various boxes was not a straightforward task because the women's experiences regarding their feelings about weight and their experiences of eating were not uniform. Indeed, given the diversity of human experience, they would not be expected to be. However, the categories were not intended to be rigid representations of feelings and experiences regarding weight and eating but rather a generalised grouping or ideal type of such feelings and experiences. Thus, all the women were able to be classified in one of the boxes for each of the periods according to their experiences. The following examples will help to clarify how the women were allocated to these boxes for the three periods of before, during and after pregnancy.

Category A: Positive feelings about weight, uncontrolled eating.

This category represented feelings of acceptance of weight and size in conjunction with eating behaviour that was 'uncontrolled' in that food was selected on the basis of want rather then what was viewed as 'good' or necessary for health or weight loss. Examples of the responses of women allocated to this group were:

Before pregnancy:

> 'I stopped worrying about my weight a long time ago, I mean, people have to take me as they find me, you know. ... I just eat what I want when I want it ... I get days when I indulge and I eat like a pig and other days when I have nothing' (Jane Clinton).

During pregnancy:

> 'I'm really pleased with my weight because I expected to balloon out ... and I haven't so it's pleased me a lot. ... I haven't changed my eating habits [since becoming

pregnant] ... we don't eat stuff just because it's healthy, we eat what we like' (Carol Smith).

After pregnancy:

'I'm thrilled about it [weight] because I've lost weight and I'm still losing it now. ... Since I've had him, I've been worse for eating than before ... it's in the evenings really ... it's just picking' (Lucy Bowles).

Category B: Positive feelings about weight, controlled eating.

This category represented similar feelings about weight to category A but in conjunction with 'controlled' eating behaviour in that food was selected on the basis of what was termed as 'good' or necessary for weight loss. Examples of the responses of women allocated to this group were:

Before pregnancy:

'I was happy with my weight, I'd lost five and a half stone through going to WeightWatchers so I was very pleased with it. ... My diet was good ... going to WeightWatchers literally changed my whole outlook to food' (Claire Whitcher).

During pregnancy:

'The weight hasn't bothered me since I've been pregnant, I'm happy with it. I'm quite amazed actually because I've only put on half a stone. ... Since I've been pregnant I am trying to think baby first and me second in terms of what I have to eat' (Judith Osborne).

After pregnancy:

'I've lost a lot [of weight] ... I'm pleased about that, definitely. I think I feel more confident now that I've lost some weight. ... I'm definitely eating differently, I'm eating better, much better ... I'm making a concerted effort to look a bit better and eat a bit better' (Katie Price).

Category C: Negative feelings about weight, uncontrolled eating.

This category represented feelings of dissatisfaction and non-acceptance of weight and size and a desire to be thinner but this desire was not

carried through to eating practices which were 'uncontrolled' as with category A. Examples of the responses of women allocated to this group were:

Before pregnancy:

> 'I've never been happy with it [weight]. I used to get very depressed about it, I still do. ... My confidence would go sky high if I was slimmer. ... I'm always eating ... All I think about is food unless I'm busy doing housework or shopping' (Brenda Gray).

During Pregnancy:

> 'I'm not happy about my weight ... I've put on four and a half stone. ... I've just eaten what I want to eat and worry about it afterwards' (Rebecca Young).

After pregnancy:

> 'I'm depressed about my weight ... I don't think it [diet] is that good. I know I still eat the wrong things. I eat far too much of the wrong things like cheese or whatever .. just too much of everything' (Amanda Spelling).

<u>Category D: Negative feelings about weight, controlled eating.</u>

This category represented similar feelings about weight to category C and similar experiences regarding eating as category B. Examples of the responses of women allocated to this group were:

Before pregnancy:

> 'I was very conscious of my size ... I'm always trying to lose weight. I don't have anything fried, all wholemeal stuff if I can and no cakes, biscuits or sweets. ... I usually try to stick to one meal a day' (Teresa Browne).

During pregnancy:

> 'I've been very conscious of it [weight] because I know, obviously, being overweight is very unhealthy for the baby. ... It seems like the most awful thing to be overweight and pregnant at the same time. ... I eat a much more healthy diet now. I'm much more conscious of what I'm eating' (Josie Robbins).

After pregnancy:

> 'I'm not really happy, no. I want to get rid of some of it [weight]. I'm eating less now and my mum pushes me to make sure I do it [diet] because I want to do it' (Michelle Pointer).

These examples, then, illustrate the types of feelings and experiences regarding weight and eating that were contained in each category for each of the three periods of before, during and after pregnancy. The typologies are set out on pages 315-317.

An examination of the three typologies reveals a *general pattern* in terms of the grouping of the whole sample in the three periods of before, during and after pregnancy. The majority of the women came into category C before pregnancy (n26, 70%) with negative feelings about their weight and uncontrolled eating patterns. However, during pregnancy there was a shift. While nearly half (n18, 49%) were in category C, nearly one quarter came into each of categories B (positive feelings about weight and controlled eating) and D (negative feelings about weight and controlled eating). There was, therefore, a shift away from uncontrolled eating to controlled eating for many of the women during pregnancy and also a shift for some women to more positive feelings about their weight. The shift towards controlled eating continued after pregnancy when just over half of the women came into category D (n19, 51%). However, there was a revertion to negative feelings about weight for most women with only eight women (22%) coming into categories A and B (positive feelings about weight).

Looking at the *movements of individual women* rather than the general pattern of the groups of women reveals the complexity of

movements between categories. In fact, comparing movements before, during and after pregnancy revealed 19 variations of movements. These can be summarised as follows:

1. Eight women (22%) stayed in the same categories before, during and after pregnancy.

2. Five women (13%) returned to the same categories after pregnancy as before but moved into different categories during pregnancy.

3. Eight women (22%) moved into different categories during pregnancy and remained in these categories after pregnancy.

4. Eight women (22%) remained in the same categories before and during pregnancy but moved into different categories after pregnancy.

5. Eight women (22%) moved into different categories both during and again after pregnancy.

The experiences of the women within each of these five groupings varied. For some, movement into other categories occurred because of a change to more positive feelings about weight but for others this occurred because of a change to more negative feelings. Similarly, remaining in a category meant a continuation of positive feelings for some but for others it meant a continuation of negative feelings. The same was obviously true for eating behaviour. The experiences of the women in each of the groupings listed above, then, were dependent on their starting position and their experiences of particular events occurring during the three phases of before, during and after pregnancy which have been discussed in the preceding chapters.

Table 16
TYPOLOGY 1: BEFORE PREGNANCY

| Category A: | Category B: |
|---|---|
| Positive feelings about weight. | Positive feelings about weight. |
| Uncontrolled eating. | Controlled eating. |
| n2, 5% of sample. | n4, 11% of sample. |
| **Category C:** | **Category D:** |
| Negative feelings about weight. | Negative feelings about weight. |
| Uncontrolled eating. | Controlled eating. |
| n26, 70% of sample. | n5, 13% of sample. |

| Category A | Category B |
|---|---|
| Jane Clinton | Pauline Barton |
| Judith Osborne | Nina Clarke |
| | Sandra Crocker |
| | Claire Whitcher |

| Category C | Category D |
|---|---|
| Lucy Bowles | Christine Barnes |
| Susan Crawford | Teresa Browne |
| Linda Dobson | Susan Hartwell |
| Angela Downer | Rosemary Kemish |
| Brenda Gray | Louise Marsden |
| Rachel Hardwick | |
| Jenny Harris | |
| Barbara Holmes | |
| Jackie Johnston | |
| Margaret Marshall | |
| Joanne McCormack | |
| Alison Norris | |
| Helen Palmer | |
| Michelle Pointer | |
| Katie Price | |
| Josie Robbins | |
| Liz Roberts | |
| Gill Russell | |
| Carol Smith | |
| Amanda Spelling | |
| Mary Thompson | |
| Fiona Tindall | |
| Anne Walker | |
| Sarah Wells | |
| Julie Woodford | |
| Rebecca Young | |

Table 17
TYPOLOGY 2: DURING PREGNANCY

| Category A: | Category B: |
|---|---|
| Positive feelings about weight. | Positive feelings about weight. |
| Uncontrolled eating. | Controlled eating. |
| n2, 5% of sample. | n9, 24% of sample. |
| **Category C:** | **Category D:** |
| Negative feelings about weight. | Negative feelings about weight. |
| Uncontrolled eating. | Controlled eating. |
| n18, 49% of sample. | n8, 22% of sample. |

| Category A | Category B |
|---|---|
| Jane Clinton* | Pauline Barton* |
| Carol Smith | Lucy Bowles |
| | Linda Dobson |
| | Barbara Holmes |
| | Jackie Johnston |
| | Judith Osborne |
| | Liz Roberts |
| | Gill Russell |
| | Mary Thompson |

| Category C | Category D |
|---|---|
| Teresa Browne | Christine Barnes* |
| Nina Clarke | Jenny Harris |
| Susan Crawford* | Rosemary Kemish* |
| Sandra Crocker | Margaret Marshall |
| Angela Downer* | Michelle Pointer |
| Brenda Gray* | Josie Robbins |
| Rachel Hardwick* | Fiona Tindall |
| Susan Hartwell | Anne Walker |
| Louise Marsden | |
| Joanne McCormack* | |
| Alison Norris* | |
| Helen Palmer* | |
| Katie Price* | |
| Amanda Spelling* | |
| Sarah Wells* | |
| Claire Whitcher | |
| Julie Woodford* | |
| Rebecca Young* | |

* Women remaining in the same category as before pregnancy.

Table 18
TYPOLOGY 3: AFTER PREGNANCY

| Category A: | Category B: |
|---|---|
| Positive feelings about weight. | Positive feelings about weight. |
| Uncontrolled eating. | Controlled eating. |
| n3, 8% of sample. | n5, 13% of sample. |

| Category C: | Category D: |
|---|---|
| Negative feelings about weight. | Negative feelings about weight. |
| Uncontrolled eating. | Controlled eating. |
| n10, 27% of sample. | n19, 51% of sample. |

| Category A | Category B |
|---|---|
| Lucy Bowles | Pauline Barton** |
| Jane Clinton** | Judith Osborne* |
| Carol Smith* | Katie Price |
| | Mary Thompson* |
| | Fiona Tindall |

| Category C | Category D |
|---|---|
| Linda Dobson | Christine Barnes** |
| Angela Downer** | Teresa Browne |
| Jenny Harris | Nina Clarke |
| Susan Hartwell* | Susan Crawford |
| Jackie Johnston | Sandra Crocker |
| Rosemary Kemish | Brenda Gray |
| Helen Palmer** | Rachel Hardwick |
| Amanda Spelling** | Barbara Holmes |
| Sarah Wells** | Louise Marsden |
| Rebecca Young** | Margaret Marshall* |
| | Joanne McCormack |
| | Alison Norris |
| | Michelle Pointer* |
| | Josie Robbins* |
| | Liz Roberts |
| | Gill Russell |
| | Anne Walker* |
| | Claire Whitcher |
| | Julie Woodford |

* Women remaining in the same category as during pregnancy.

** Women remaining in the same category as before and during pregnancy.

To illustrate how the movements of women between categories were dependent on their experiences before, during and after pregnancy I will describe three case studies. The first case study is of a woman who stayed in the same category (category C: negative feelings about weight and uncontrolled eating) before, during and after pregnancy. This case study illustrates how, for this woman, the experiences within pregnancy and early motherhood were not enough to change either her feelings about her weight or her eating behaviour. The other two case studies are of women who moved between categories and these illustrate how important their experiences during pregnancy and early motherhood were in causing changes in their attitudes and behaviour regarding weight and eating.

Case Study 1: Angela Downer.

Angela was very unhappy about her weight before pregnancy and reported that it prevented her from taking part in a range of social activities. She had tried to diet many times but always without success. Angela attributed the primary reason for her size to the fact that her partner had a preference for meals that were high in fat content. She felt that she should cook her partner the types of meals that he wanted but also felt that, because she worked full-time she had neither the time nor the energy to cook separate meals for herself. This meant that she consumed the same meals as her partner. Additionally, Angela ate a lot of snack-type foods between meals, particularly chocolate, and tended to eat when she felt upset. Before pregnancy, then, Angela's attitude to her weight and eating could be characterised as coming into category C: negative feelings about weight and uncontrolled eating.

During pregnancy Angela felt slightly happier about her weight both because initially she put on what she felt was only a small amount of weight and because she felt that it was more acceptable to be fat during pregnancy. However, this shift was slight and overall Angela still felt dissatisfied with her weight and size and expressed negative feelings about it. She ate in a more uncontrolled fashion during pregnancy and always followed cravings for food, such as chocolate, and ate whatever foods she fancied where possible while continuing with the pre-pregnancy diet of high fat meals that her partner wanted. Her diet appeared to be largely unaffected by advice or by her emotional well-being during pregnancy. During pregnancy, then, Angela's attitude to her weight and eating could be characterised again as coming into category C: negative feelings about weight and uncontrolled eating.

After pregnancy Angela felt even more unhappy about her weight than she had done before pregnancy. This was primarily because she had gained a lot of weight during late pregnancy and as a consequence weighed more after pregnancy than before. She had been advised by medical professionals to lose weight and indeed wanted to do this but after an initial failed attempt after her baby's birth had reverted to her previous pattern of uncontrolled eating. Again the primary reasons for this were issues relating to the practical and ideological organisation of food and eating. For Angela, then, the experiences within pregnancy and motherhood were not enough to fundamentally change her feelings about her weight and her experiences regarding her eating. Angela was locked into negative feelings about her weight because she was unhappy about being fat but was powerless to do anything about this because of the perceived necessity of catering to her husband's food

preferences. The hopelessness of this situation probably contributed to greater incidence of uncontrolled eating behaviour, such as eating chocolate and snacks, and this probably led in turn to greater negative feelings about her weight and size. After pregnancy, then, Angela's attitude to her weight and eating could still be characterised as coming into category C: negative feelings about weight and uncontrolled eating.

Case Study 2: Judith Osborne.

Judith was reasonably satisfied with her weight before pregnancy. She had always been fat and had been on a number of diets but had reached a point of acceptance of her weight and size. She tried to consume a reasonably healthy diet in terms of meals but tended to eat what she fancied between meals and to 'pick' at various snack-type foods during the day. She was not dieting. Judith's attitude to her weight and eating before pregnancy could be characterised as coming into category A: positive feelings about weight and uncontrolled eating.

During pregnancy Judith maintained a similar positive attitude to her weight as she perceived her weight gain to be low. However, her eating behaviour changed quite markedly from uncontrolled to controlled eating. This occurred primarily because she wanted to restrict her weight gain and so that her unborn baby would reap the benefits of a 'healthy' diet. As a result she cut out the foods that she viewed as 'unhealthy' from her diet and ate more of the foods that she viewed as 'healthy'. Judith's attitude to her weight and eating during pregnancy could be characterised as shifting from category A to category B: positive feelings about weight and controlled eating.

After pregnancy Judith maintined positive feelings about her weight and she expressed satisfaction that she weighed less after pregnancy

than she had done before pregnancy. However, she maintained the same sort of 'healthy' diet that she had consumed during pregnancy. This was not because she was trying to lose weight but rather because she felt that it was important in terms of her and her baby's health to consume a 'good' diet particularly as she was breast-feeding. Judith's emotional well-being was quite high in the early weeks of motherhood and she expressed satisfaction with motherhood. This may have been a factor in enabling her to maintain both positive feelings about her weight and control over her eating. Judith's attitude to her weight and eating after pregnancy could be characterised as category B as it was during pregnancy: positive feelings about weight and controlled eating.

Case Study 3: Teresa Browne.

Teresa was dissatisfied with, and very self-conscious about, her weight and size before pregnancy. She had tried a number of diets over the years and had found that the only way she could keep her weight stable was to restrict her food intake quite strictly. This she did by allowing herself, in general, to eat only one meal a day. She cooked her food separately to her partner's so that he could still eat the types of food that he enjoyed and she could eat the types of food necessary to keep her weight stable. However, even keeping her weight stable led to feelings of dissatisfaction about her weight. Teresa's attitude to her weight and eating before pregnancy could be characterised as category D: negative feelings about weight and controlled eating.

During pregnancy Teresa's negative feelings about her weight intensified because she put on considerably more weight than she had anticipated. The reason for her large weight gain was primarily the

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following discussion will be an examination of some of the factors which may lead fat women to adopt particular attitudes or strategies to their weight and eating and the implications of these for medical professionals. Following this, I will go on to discuss possible longer-term outcomes for the women in these groups. Finally, I will return to the topic of the achievement of a positive self-image for fat women unassociated with dieting and weight loss.

## 6.2 VULNERABILITY AND PROVOKING FACTORS INFLUENCING ATTITUDES TOWARDS WEIGHT AND EATING

It is unsurprising that for most of the fat women interviewed for this research, their feelings about their weight were related to the actual amount that they weighed and the only action that was viewed as having the potential to improve feelings about weight was a change in eating habits leading to weight loss. A closer examination of how and why this occurs and the potential for any change in this situation will be focused on in more detail below. The focus in this section is not why the association between weight and feelings occurs nor what could be done to change it but rather why some women in the study were motivated to try to change or maintain positive feelings about their weight through controlled eating and eventual weight loss or weight stability whereas others were not.

I have already noted some of the important factors that may have made it more or less likely that weight loss attempts through controlled eating would be undertaken by the women after pregnancy. These may have led to the dichotomy that existed between the women in terms of actions

regarding their weight and eating. These will be returned to in examining longer-term outcomes. However, there are some classificatory factors that it is necessary to examine before moving on to this. Factors such as social class, age, and number of children may have had an impact in determining which women went on to attempt weight loss through controlled eating and which women did not. The following table sets out the differences in social class, age and number of children between the two groups:

Table 19

Social Class, Age, and Number of Children

| Classification: | Group 1 (n24) | Group 2 (n10) |
|---|---|---|
| *Social Class:* | | |
| Working Class | 12 | 7 |
| Middle Class | 9 | 3 |
| Cross Class | 3 | - |
| Mean Average Age | 25 years | 26 years |
| *No. Of Children:* | | |
| One Child | 15 | 3 |
| Two Children | 7 | 4 |
| Three Children | 1 | 2 |
| Four Children | 1 | 1 |

The numbers involved here are quite small, especially in group 2, and this makes it difficult to draw conclusions relating to these classifications. However, two differences between the groups warrant

discussion. First, out of the women who had recently given birth to their first child, a far larger proportion attempted to employ controlled eating practices in order to lose weight than those who did not employ such eating practices. Secondly, a larger proportion of the middle-class women in the sample attempted controlled eating than did not. These two factors may be important contributory factors, probably operating alongside the other factors already discussed, in encouraging (or discouraging) women toward controlled (or uncontrolled) eating. These factors may be seen, when they operate in a negative way, as possible 'vulnerability factors' making moves toward controlled eating and consequent positive self-image less likely. The concept of vulnerability factors has been discussed at length in relation to women and mental illness (Brown and Harris, 1978). However, the use of the term here differs to that used by Brown and Harris. In Brown and Harris's study vulnerability factors were viewed as causing or contributing to depression. In this study vulnerability factors are not causal or contributory to fatness but rather to particular attitudes in relation to fatness.

The way that these factors might be likely to operate is as follows. In the case of number of children, it is likely that women with only one child would be more likely to attempt controlled eating practices for a number of reasons. First, they are likely to be more acutely aware of a change in their body shape and size than women who had experienced previous pregnancies and also to be less entrenched in the image of themselves as mothers. A consequence of this might be a strong desire to return to the body shape that they had before pregnancy or to strive to achieve an even slimmer shape than before pregnancy in

order to feel sexually attractive. Secondly, while caring for a baby is often a very disruptive experience for first-time mothers it is likely that they would have more time to devote to a consideration of their diet than women with two or more children, particularly if these children were under school age. In addition to this, there was some evidence emerging from the interviews that one child tended to be viewed as 'fitting in' to the couple's or mother's lifestyle to some degree whereas the birth of a second or subsequent child was viewed as marking the transition from a couple plus baby to 'a family'. One possible outcome of this might be that women with one baby might be more likely to give some priority to their own needs and wants and thus to attempt to control their eating in order to attain their objective of slimness. Women with more children might be more likely to put 'the family' first, thus allowing little time or energy to pursue their own objectives.

There was some evidence from the data for this. Out of the 17 women who had given birth to a second or subsequent baby, six reported that they had to some degree 'given up' hopes of achieving a slim and attractive body. Of the remaining women in this group, a further six were in cross-class or middle-class families and this may have been a factor that prevented them from adopting this attitude. This will be discussed below. None of the women who had given birth to a first child reported that they had 'given up' striving for a physically attractive body. The following quotations illustrate how the number of children a woman has may have an impact on decisions regarding eating behaviour. The first quotation is from a first-time mother and illustrates the strong feelings that changes in shape as a result of pregnancy and

childbirth engender and an awareness that prompt action to rectify it needs to be taken:

> 'I feel horrible. I don't know ... it's the stretch marks and the flabbiness ... If I don't do something about it now, it'll become: "Oh, that's just how I am" and I don't want that'
> (Alison Norris).

The second quotation is from a woman with two children who notes the transition to becoming 'a family' with the birth of her second child. This, as I have noted, might have an prohibitory impact on actions centred on a woman's self-interest, such as dieting:

> 'I feel older being a mother of two, more mature. It's definitely made us more of a family having two children. Whereas she [first child] just fitted into our coupled life, if you see what I mean, whereas now it's a family'
> (Katie Price).

The final quotation is from a woman with four children, two of whom are of pre-school age. She notes the lack of time available to consider her diet:

> 'I still would like to get [my weight] back down ... and I'm not eating that much right now but I just have so little time to think about it properly'
> (Sarah Wells).

In terms of social class, it is likely that middle-class women might find it easier to employ controlled patterns of eating than working-class women for two reasons. First, they are likely to have greater material resources at their disposal and secondly they are likely to have a higher degree of social support from their partners and/or others. In terms of material resources, middle-class women are likley to have a higher level of familial income which would enable them to buy food for them to consume that might be additional to foodstuffs bought for meals for the rest of the family. In addition, middle-class

women are more likely to be able to afford to join a slimming club, such as WeightWatchers, which would provide them with the practical and emotional help to assist with weight loss.

Social support is also likely to be very important in enabling women to diet. There is some evidence that men and women in working-class families have more traditional segregated roles than middle-class families (Charles and Kerr, 1988) and this may mean that men in working-class families offer less help and support to their partners' weight loss attempts both in practical and emotional terms. In practical terms, men in working-class families may see it as their partner's role to plan, prepare and cook 'proper' meals for the family regardless and may contribute little to these tasks. This may militate against dieting success for working-class women. Similarly, in emotional terms, working-class men may offer less support in terms of encouragement to their partners because they do not view this as an area of their concern. In addition, attitudes to health vary between the social classes and the greater support from partners and others (usually mothers) with weight loss amongst the middle-class women may be associated with their greater concern with positive health behaviour (Armstrong, 1983). This may have been an additional factor encouraging middle-class women to diet of their own volition but this seems less likely given that it was appearance rather than health issues that were invariably referred to by the women in talking about their dissatisfaction with their size.

There was only limited evidence from the data that a lack of material resources made it more difficult for working-class women to employ controlled patterns of eating. However, there was considerable

evidence that effective support from family members was class-based to some degree. Of the 13 middle-class women in the sample, six noted that their partners (or in one case, parents) gave them practical encouragement and support to lose weight. Conversely, out of the 21 working-class women in the sample, 15 noted that their partners (or parents) were uninterested or obstructive in relation to their weight loss attempts. The following quotations illustrate these points. The first is from a working-class woman who highlights the financial constraints inherent in following a diet. The second is from a working-class woman who notes how the lack of social support from both her partner and her mother made dieting difficult, and the third from a middle-class woman who notes that the support she received from her parents (with whom she was living) was helpful in enabling her to diet:

> 'I started going to WeightWatchers to lose some weight but I only went for a few weeks because it's so expensive. I just couldn't afford to keep going'
> (Mary Thompson).

> 'He (partner) does have his comments ... I know he means well but he's the sort of guy who'll say: "Oh yes, you definitely need to lose some weight" and give you a dig about it one day and he'll come home with a bar of chocolate the next which is not really what I need. He goes: "Oh sorry, I just thought it would be a treat". But it's the wrong sort of treat, not a good idea. But I'll sit there and eat it. ... My mum's had a few digs. She says to me, "When are you going to start this diet?" And I says, "When I'm in the right frame of mind" and she says, "You're never in the right frame of mind"'
> (Brenda Gray).

> 'We're all on a diet, the whole family's on a diet. ... My mum and dad watch what I eat. They would make sure that I didn't eat anything that was really fattening because they're so conscious of their weight as well. My mum's always had to cope with the fact that I've been overweight and so she's always watched what I've eaten. ... Moving back in with my parents was really beneficial in terms of my diet'
> (Josie Robbins).

Thus, being working-class and having two or more children, particularly where more than one child is under school age, may be factors that make fat women vulnerable to inaction regarding their weight. These factors may operate by making fat women who feel negatively about their weight and size feel either unable (because of a lack of time, money or social support) or unwilling (because of feeling entrenched in the role of mother) to control their eating and thereby to bring about more positive feelings about their weight and size. These vulnerability factors are likely to operate in conjunction with the experiential factors identified above and in the preceding chapters. Following the analysis used by Brown and Harris (1978) I have used the term 'provoking factors' to refer to the negative experiential factors. The terms vulnerability factors and provoking factors have been used as the factors they encompass appear to operate in much the same way as those identified by Brown and Harris in their study. However, here they are not causal or contributory to a particular condition (or illness) but rather to attitudes relating to it. The distinction between vulnerability and provoking factors used here is that vulnerability factors are facts that exist for all people and are unchangeable, such as, whether a child is the firstborn in a family. On the other hand, provoking factors are experiences that not everyone encounters and where the level and depth of individual experience may vary. The way that these factors operate together is as follows. The vulnerability factors of class and parity (number of children) are likely to make women experiencing them particularly vulnerable to feeling unable to undertake controlled patterns of eating. Where these factors meet with negative experiential factors occurring after pregnancy, this may turn a

vulnerability into a reality. The impact of the negative experiential factors is likely to be greater according to the number that are experienced. It is probable that the negative experiential factors, when they occur in conjunction with vulnerability factors, would operate in a cumulative way making those who experience more of them more likely to react by feeling unable to change their situation and to employ controlled patterns of eating. The vulnerability and provoking factors identified as leading women to take no action regarding their weight and eating after pregnancy were as follows:

Vulnerability Factors

Being working-class.

Having two or more children, especially if more than one were under school age.

Provoking Factors

High post-pregnancy weight or a high weight gain comparing pre- and post-pregnancy weight.

Low emotional well-being.

The experience of strong constraints against dieting through the practical and ideological organisation of food and eating.

Receiving no constructive advice regarding dieting from either the medical profession or kin and friends.

Given that these vulnerability and provoking factors may predispose fat women to take no action regarding their weight after pregnancy, even though they feel negatively about their weight and size, it is important to look at the implications that this may have for the women themselves and for medical professionals in terms of the advice that they might usefully give. Before moving on to discuss the implications for medical

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pessimism and despair to those of optimism and hope. The following quotations illustrate the different outlooks of the two groups of women. The first two are from women who had negative feelings about their weight but who had no immediate plans to diet, and these illustrate the pessimism arising from this attitude. The second two quotations are from women who had started dieting in order to lose weight and to achieve more positive feelings about their weight. These illustrate how this action can lead to a more positive outlook.

> 'I haven't lost any [weight]. What I gained in pregnancy, I haven't lost any of that. I've come to accept now that I'm going to be fat for the rest of my life so I might as well accept it and there's no point in dieting. When I first had her [baby] I thought: right, that's it, I'm going to lose this weight. But then when I sat here and really thought about it and there was all these dieting things on the telly and I thought: what's the point? I'm always going to be fat. I don't like it though. I feel worse than I did even before I was pregnant but I don't see what I can do about it'
> (Susan Hartwell).
>
> 'I'm depressed about my weight ... I don't know how much I weigh but it's too much. ... My husband said I could have some money to buy some new clothes so I went out last week ... but nothing looked really nice ... it just looked horrible because of my stomach so I thought: oh, it's not worth it, I might as well wait until I lose some weight. But at the moment I don't know what I'm going to do about it'
> (Amanda Spelling).
>
> 'At the moment I weigh about 15 stone (96kg.) but hopefully I'm going to lose some of that, well I want to. This time I've got my heart into losing some weight. I'll do it this time'
> (Christine Barnes).
>
> 'I think I feel more confident now that I've lost some weight. I've become more of a smarter dresser now. I make much more effort because I think now that I've lost this weight and I feel a bit more confident and I want to look nice'
> (Katie Price).

Thus taking or not taking action to lose weight had considerable implications for the women in this study. Those women identified above who were unable to take action to lose weight were likely to find themselves even further entrenched in the negative feelings that they had about their weight. The effect of this may have been to increase social isolation and feelings of low self-worth. These feelings may make the possibility of future weight loss attempts even less likely.

## 6.4 IMPLICATIONS FOR MEDICAL PROFESSIONALS

The finding that some women feel able to employ controlled patterns of eating after pregnancy while other women do not, and that certain vulnerability factors in association with certain provoking factors may account for this, has implications for medical professionals. As has been noted, the women in this study did not, in general, receive advice from medical professionals regarding their weight after pregnancy. However, while it appears that medical professionals *do not* routinely give advice about weight to fat women after pregnancy it does not follow that they *should not* give such advice. It is not possible to determine whether there are serious health risks associated with fatness but there is a wide literature suggesting such health risks (Burton et al, 1985) and this, in association with the strong desire to lose weight expressed by the majority of the women in this study, are valid reasons for medical professionals to give advice, help and support regarding weight loss to fat women.

I do not wish to argue here that all medical professionals should encourage all fat women to lose weight after pregnancy. Rather, I am

arguing that where fat women feel negatively about their weight and size and a desire to be slimmer, as most of the women in this research did, then medical professionals should see it as their concern to help their clients to this goal. There are of course questions here about the power of the medical profession and their role as agents of social control in, for example, setting definitions of fatness. These issues have been discusssed in previous chapters and I do not intend to re-examine them here. For the purposes of this discussion I am taking the self-definition of fatness employed by the women as unproblematic and I am viewing weight loss as a desirable goal because this is what the women wanted. The possibilities of fat women achieving positive feelings about their weight and size without losing weight will be discussed below.

In the following discussion I will identify the ways that medical professionals can best help fat women who feel negatively about their weight and desire weight loss but who nevertheless find dieting difficult. This relates specifically to the women, identified above, in group 2 who felt unable to diet, and illustrates the sorts of help and support that would assist them to this end. Additionally, the discussion has some relevance for the women identified above as in group 1, who, while they felt able to diet, may have benefitted from greater help, support or understanding from medical professionals. Given G.P.'s contact with women during the post-natal stage, they are likely to be in the best position to give advice and support regarding weight loss in the initial stages. However, G.P.'s are unlikely to have either the time or the expertise to give continued advice and support regarding weight loss. Community health visitors or dieticians may be the most

appropriate medical professional to provide this advice and support in the longer term.

The vulnerability and provoking factors identified above demonstrate that, before a medical practitioner can offer support, help or advice to fat women who find dieting difficult, he or she needs to gain knowledge of the social situation of the women. This knowledge of women's social situation needs to be in relation to two main topics. First, in relation to the practical and ideological organisation of food and eating in the family and, secondly, in relation to their emotional well-being. Within the topic of the practical and ideological organisation of food and eating, there are four areas which the G.P. would need to discover information about. These areas are: first, who chooses the foods that are eaten in the home; secondly, what is eaten; thirdly, who does the cooking; and fourthly, issues of time, energy and money in relation to food consumption.

The importance of who chooses the foods that are eaten in the home is likely to be significant in respect of a woman's ability to control her food intake. As has been noted, male partners and children often dictate what foods are eaten at mealtimes. Indeed, evidence from existing literature and this research has shown that children follow male partners in the hierarchy of importance in this respect (Charles and Kerr, 1988). As well as dominating the types of foods that are eaten at mealtimes, partners and children often determine the types of foods that are kept in the house for snacks or packed lunches for work or school. Again, these may affect women's ability to control their food intake. Thus, where male partners and children dominate both the types of meals that are eaten and the types of foods that are kept in

the home, this is likely to have an impact on a woman's ability to control her food consumption.

It is important that the medical practitioner is aware of who makes the choice of food and what this choice means in terms of the foods that are bought and consumed. Furthermore, and probably of even greater importance, is the necessity of discovering what this choice means in social terms. For example, where families consume a 'fattening' diet as a result of women catering to partners' food preferences, it is necessary that the social importance that the women and their families attach to meals and mealtimes and to having male partners and childrens' food preferences catered for is uncovered. Only by discovering this can any understanding of the possibility of a change in eating practices be reached. In families where mealtimes are viewed as important 'family' occasions and where partners' food preferences dominate, women are likely to experience difficulties in changing their diet. Cooking and eating separate meals for themselves is likely to be difficult both practically and because of the social importance of family mealtimes which demands that all family members share the same food and eat at the same time. The alternative of changing the whole family's diet to fit in with the food that the woman wants to consume is also likely to be difficult. Ideological notions of women's roles in relation to men regarding food preparation and consumption are often deeply entrenched. As a result, changing from the domination of men's food preferences to women's may result in guilt from the woman and resentment from her partner. This latter point was brought out clearly by one of the interviewees:

> 'Now and again I think to myself: well, why should we [herself and her child] just have to eat what he likes? Why

shouldn't he eat something now and again that we do? So, you know, just a couple of nights a week I do something a bit different, like I might do boiled potatoes and gravy or roast potatoes or just something away from the chips that he likes. Some days he'll eat it and other days he won't. He won't moan about it unless he says it in a sort of joking way but if you say "Aren't you going to eat it?" he says "You know I don't like it" and then you feel guilty because I think to myself he's only gone to work on sandwiches and then he's coming home and I'm giving him something he's not particularly fond of and so you do feel guilty about it'
(Angela Downer).

Thus the social significance attached to food and mealtimes by individual families is likely to be a crucial aspect in determining which women are able to start and continue with controlled patterns of eating and which women are not. Discovering information about the social significance of food choice in families is, therefore, a necessity before medical practitioners can begin to offer advice or support to women. It may be that for some women, because of the factors discussed above, a complete change to controlled patterns of eating is not possible and that change can proceed only at a slow pace by, for example, eating in a controlled fashion for only one or two days a week. Furthermore, talking to male partners with the aim of getting their co-operation is likely to be important in some cases although whether this could be achieved might be debatable given the ideological basis of food choice. Whatever type of advice or support that is seen as appropriate, it is clear that it must be suited to individual circumstances that take the social factors of food choice into account.

The second area of importance is the social significance of the food that is eaten at mealtimes. This relates not so much to the precise content of meals but rather to the notion of what a 'proper'

meal consists of in terms of types of food. Research has identified that a 'proper' meal is understood as the main meal of the day that is consumed with all family members present and consists of meat, potatoes and vegetables (Kerr and Charles, 1986). Other types of meals such as beans or egg on toast or salads are viewed as snacks rather than 'proper' meals. Consumption of the 'proper' meal, and the ideological practices surrounding it, has been identified as being an important part of family life. It is likely to be important, then, that medical practitioners gain some understanding of their patients' notions of 'proper' meals and the importance that they attach to this. Again, merely advising women to eat or avoid particular foods might not be translated into successful patterns of controlled eating if these do not fit into notions of 'proper' meals. For example, advising women to eat salads or to avoid red meat may mean that some women feel that if they followed this advice they would not be eating 'proper' meals and as a result would not be part of an important family ritual: that of the 'proper' family mealtime. The family mealtime has been identified as central in affirming and reproducing the importance of the family unit and thus feelings of exclusion from this may be problematic. It is likely that advising women who have strong notions of 'proper' meals to eat foods that cannot be incorporated into 'proper' mealtimes may mean that such advice is not followed. Indeed, this point is noted by Murcott in relation to dietary advice given in pregnancy. She argues that 'While advice on diet in pregnancy makes good nutritional sense, it may not be making as good 'social' sense and thereby risks failing in intention' (Murcott, 1982b:9).

The third area of importance in relation to women's ability to control their food intake relates to the practical organisation of meal preparation. As has been noted it is generally women who are primarily responsible for meal preparation in the home and the constant contact with food that results from this responsibility presents difficulties for women attempting to control their eating. It is important that the medical practitioner discovers the precise nature of the male partner's participation (or lack of it) in meal preparation and the possibility of further participation. For some women, it may be possible for them to enter into more controlled patterns of eating only if their partners relieve them of some of their 'responsibilities' that bring them into such constant contact with food. Whether partners would be willing to do this is another matter but again medical practitioners might talk to them in an attempt to gain their co-operation in this. Certainly, an understanding of women's domestic situation is essential for relevant advice and support to be given.

The fourth area of importance in relation to women's ability to control their food intake relates to constraints imposed through issues of time, energy and money. I have noted that such constraints determined the sorts of diets that some women consumed. For example, women on low incomes often noted that they could not afford to buy 'dieting' types of foods or to join weight-control groups and women in paid employment or with heavy domestic responsibilities reported having neither the time nor the energy to cook specific meals for themselves in addition to the 'family' meal. For there to be some likelihood of advice being followed, it is essential that medical practitioners take these factors into account. In situations where women are managing on

low incomes, for example, it is pointless to recommend a diet that demands buying expensive foods. Additionally, where women have heavy demands on their time it is pointless advising them to eat meals that either take a long time to prepare or cannot be incorporated into the meals consumed by the rest of the family.

Thus, for medical practitioners to give advice and/or support to fat women who wish to diet that has some likelihood of being followed, it is crucial that information is sought and incorporated into realistic advice on the four areas discussed above. These areas have been identified from the vulnerability and provoking factors discussed above and related either singly or multiply to a number of women in the study. Medical practitioners alone do not dictate the success or otherwise of dieting efforts and indeed, in the area of the practical and ideological organisation of food and eating, partners have a crucial role in determining whether women can achieve controlled patterns of eating or not. Nevertheless, medical practitioners do have an important role to play in giving advice that is appropriate to women's lives. The experience of one woman who had extreme difficulties in maintaining controlled patterns of eating relating to each of these areas sums up the inappropriateness of advice from the medical profession that fails to take these social factors into consideration:

> 'I went to see my doctor one day ... and he suggested that I saw a dietician. So I did but to be honest I found them no help at all because she was simply telling me what foods I could eat and what foods I couldn't. I *know* that, I mean, I *know* what foods I should be eating and what foods I shouldn't be eating but it's the difference between knowing what you should be doing and actually doing it. So I didn't bother to go to her anymore because I thought she was no help. Anyone can tell you that it's good to eat chicken, not red meat and to eat lots of vegetables and fruit but actually coming to do it is a different matter' (Angela Downer).

The other factor needing consideration by medical professionals in giving advice to fat women regarding diet was identified as being women's emotional well-being. The period of time being discussed here is a few weeks after childbirth. This, it will be recalled, is a time when women may be vulnerable to low levels of emotional well-being for a number of reasons and such a state is not conducive to dieting given that a large degree of determination is necessary for successful weight loss. Additionally, the impact of failure is likely to have far more negative consequences if a woman is feeling emotionally vulnerable. Failure of dieting attempts is experienced negatively at the best of times. However, women who feel in a 'low' state of mind in the early weeks of motherhood may experience these negative feelings even more acutely as they are likely to compound existing negative feelings. A failed dieting attempt at this time may mean that women give up trying to diet and resign themselves to a future of being fat.

Thus, both because dieting attempts are likely to be unsuccessful at times when fat women have low levels of emotional well-being and because the impact of this may be great, it is important that medical practitioners take this into account before deciding the type of advice or support that they can offer fat women in the early weeks after childbirth. Primarily, it is important that an assessment is made of the time, the motivation and practical help and support available at this point. In order to discover this, it is necessary that information is discovered on the following two areas: first, the woman's feelings about the baby and satisfaction with motherhood; and secondly, her domestic situation, that is, the size of her household, whether she is in paid employment and the contribution others make to domestic work and

childcare in the home. Information on the first of these areas would enable the medical practitioner to discover if the woman had the motivation to undertake a diet and information on the second area would shed light on whether she had the practical support and time to undertake a diet at this time.

The effect of women's feelings of satisfaction with motherhood and the importance of their domestic situation in enabling them to embark on a diet has already been discussed. The important point here is the type of advice and/or support that medical practitioners can give to women that takes these issues into account. It is important that an assessment of women's emotional well-being is made by gaining information about women's feelings and their social situation at this time and that advice and/or support is given that relates to this. For example, if women's emotional well-being is low at this time it is sensible to discuss possible plans for dieting in the future rather than to advise immediate dieting that might end in failure. In such cases, it would be necessary to see the woman at regular intervals to re-assess her situation and to plan the most appropriate time when a diet could be undertaken. In addition, it is necessary that advice, when it is given, is specific to individual women's social situation. Merely giving out diet sheets is not an adequate form of advice. Women with little time to spare because of employment and/or the demands of a family, with sometimes little support from partners, are unlikely to feel able to stick to a diet that involves weighing out specific amounts of food or buying special foods, especially if medical practitioners offer no additional support or encouragement. The following quotations

illustrate these points. The first is from a woman who had a particularly low level of emotional well-being in the early weeks of motherhood resulting from her feelings of dissatisfaction with motherhood. She notes the lack of support from her doctor regarding her attempt to lose weight:

> 'He [doctor] said "You've got to lose some weight" and I said "Yeah". I said "I've been on a diet and I'm not getting anywhere" and he said "Well, keep at it" and I said "But I'm not getting anywhere". He said "I know but just keep it up"
> (Rachel Hardwick).

The second quotation is from a woman who notes the inappropriateness of being given a diet sheet by her doctor:

> 'I went to the doctor and I said "Have you got a diet sheet?" and he gave me that which I've just sort of browsed at because it wasn't what I really wanted. I want something that's mapped out for me daily'
> (Brenda Gray).

The third quotation is from a woman who received more realistic advice that fitted in with her situation. Perhaps significantly this advice came, not from her G.P., but from a midwife:

> 'The nurse [midwife] advised me to wait another few weeks so that I can get myself into a routine and that before I try too hard. So I'm taking her advice. I thought, well, it's got to be the easiest thing, get us both into a routine and that. Because I did go on one diet before that made me really miserable and, I mean, that's the last thing I need to do at the moment, to go on a diet and get myself into a right state over it'
> (Rosemary Kemish).

Thus, it is important that the sort of advice regarding diet and weight loss that is given by doctors to fat women at this time relates to women's emotional well-being and their social situation.

## 6.5 LONGER-TERM EFFECTS

It should be noted that the above discussion relates to the situation of the fat women interviewed in this study at one particular point in time: a few weeks after childbirth. It was not possible within this thesis to examine longer-term outcomes because of constraints of time. Thus, this gives only a snapshot picture of the women's feelings about their weight and their experiences regarding their eating. Such feelings and experiences are not static and are likely to change as situations change. For women in the early weeks of motherhood specific changes are inevitable. Within the first year of life babies change from being completely dependent, unsocial beings whose primary needs are for sleep and food into semi-independent, sociable beings with multi-faceted needs. Mothers, where they are the chief carers of their children, are also subject to great change in their lives as a result of the development of their child. In addition, changes unrelated to motherhood may occur, for example changes in employment and housing, and these too may have an impact on feelings about weight and eating practices that existed as a result of pregnancy, childbirth and the early weeks of motherhood.

It is, of course, not possible to say what changes will occur to the women interviewed for this study in the future and consequently what their long-term attitudes and experiences regarding their weight and eating will be. Nevertheless, from the data collected and particularly from that which related to the women's feelings and experiences regarding their weight and eating before pregnancy, I would argue that the majority of the women in this study (that is, those 34 women discussed above whose feelings regarding their weight were connected to

their eating behaviour) would form three groups in the longer-term on the basis of their attitudes towards their weight and eating. I have called these three groups the 'fatalist' group, the 'fluctuator' group and the 'maintainer' group. These groups are intended to be 'ideal-types' in that they each approximate to general types of attitudes and feelings about weight. Each of these groups can be characterised as follows by a particular attitude to eating which has a consequence for feelings about weight.

1. The Fatalist Group.

This group comprises women who had given up hopes of losing weight and had resigned themselves, unhappily, to a future of being fat. Women in this group would have a negative attitude to their weight, and uncontrolled eating practices.

2. The Fluctuator Group.

This group comprises women who were on frequent diets and who were dissatisfied with their weight but who found that they could not change their pattern of eating permanently. Women in this group would break a diet because they got bored with it, felt unable to tolerate it or because it was successful and achieved some weight loss. However, even when weight-loss occurred, the effects were not permanent and after a period of non-dieting a diet would be resumed because of feelings of dissatisfaction with their weight. Women in this group would move between negative and positive feelings about their weight and controlled and uncontrolled patterns of eating according to their stage in the dieting/non-dieting cycle.

3. The Maintainer Group.

This group comprises women who were able to achieve weight stability through sustained controlled eating. Women in this group could have a negative or positive attitude regarding their weight according to the level of weight, and their perception of this, that their controlled eating allowed them to maintain.

The identification of these three groups has been based on an examininationation of the women's past experiences regarding their weight and eating before pregnancy. At that point the women comprised, in general, three groups: those who had given up dieting, those who dieted on and off almost constantly, and those who were 'successful' dieters. (The further group of those who were satisfied with their weight but were not dieting has been dealt with separately.) I would argue that, in the longer term, the women in this study could be allocated to one of the three 'ideal type' groups outlined above. Obviously it is not possible to allocate accurately *individual* women to the groups given that no data were collected on longer-term post-childbirth outcomes. A variety of events and occurrences could happen that would influence which category particular women ended up in. Nevertheless, I feel it is possible to say that the majority of the women in this study would end up with longer-term feelings and attitudes that fitted into these three groups just as they did before pregnancy. While it is not possible to examine individual events and experiences that may occur to women in the longer-term which may lead them towards one of the groups, it is possible to discuss some of the social factors that make it more or less likely a woman would become a fatalist, fluctuator or maintainer in terms of attitudes to her weight and eating.

Group 1: Fatalists.

A number of social factors might lead women to become fatalistic about their weight and to give up dieting attempts and all hope of becoming slim. Such women would be likely to have a history of unsuccessful attempts at losing weight. Their lack of success in these attempts is likely to be related to social factors such as a lack of practical and emotional support from partners and/or kin and a traditional attitude towards the practical and ideological organisation of food and eating in the household. These factors make long-term dieting attempts difficult and make failure a strong possibility. To a large degree this is often the 'fault' of partners who fail to support dieting attempts if they result in a change in role, custom or practice relating to food preparation and consumption. Additionally, women in this category might be significantly overweight and have a long history of weight problems. This may mean that they have adapted their lives to being fat women with possibly low levels of social contact and low self-esteem. The result of these factors may be that such women give up all hopes of ever becoming slim, a state which they feel very unhappy about, but which they feel powerless to change. The following example describes a woman who displayed a fatalistic attitude to her weight after pregnancy and who could be predicted to develop a fatalistic attitude to her weight in the long-term:

Susan Hartwell.

Susan had been fat from about the age of seven and had been on a large number of diets, all of which had been unsuccessful. She was considerably overweight by medical standards. She felt very dissatisfied with her weight and had a negative view of herself

resulting from it which constrained her social activities. She felt that dieting was part of the problem which contributed to her weight because each time she dieted she ended up weighing more after coming off the diet than she had done before. She gained a lot of weight during the pregnancy which before the birth she reported feeling determined to lose. However, she did not lose this weight and after the birth of her baby reported that she had given up trying. Her partner had contributed considerably to domestic work and cooking in the home during her pregnancy but after the birth of the baby reverted back to, in her words, 'doing nothing'. He worked away from home for long periods and during this time mealtimes centred around the children. She gave little consideration to her food choice and tended to eat whatever was to hand.

Group 2: Fluctuators.

Women who became 'fluctuators' in terms of their weight and eating would be likely to have a long history of dieting attempts which were initially successful but where a revertion to original weight occurred after dieting stopped. A high incidence of comfort eating is likely for this group and this might be a cause of repeated breaks in dieting. In comparaison with the 'fatalists' outlined above, this group are likely to have: greater support from their partners and a less rigid organisation of food and eating in the household; less weight to lose; to have experienced large fluctuations in their weight throughout their lives; to experience their weight as a slightly less constraining element in their lives; and, to feel optimistic about *eventual* success in terms of weight loss although they still may experience their weight in a negative way. The following example is illustrative of this general type:

Barbara Holmes.

Barbara recalled becoming fat in her teens and noted that this increased after her marriage and her first pregnancy. She felt dissatisfied and self-conscious about her weight but did not let it interfere with her social activities to any great degree. Following her first pregnancy she dieted on and off almost constantly. Regarding this tendency to diet in a cyclical pattern she noted 'I was always having a go with diet sheets and then I'd lose interest and stop and that was it again'. In addition, she noted that she ate for comfort when she was lonely or fed-up and that it was this that was 'the problem' that caused her to be fat rather than the types of meals that they ate. After the birth of her baby she planned to go to WeightWatchers and start dieting. She felt it was possible to incorporate such a diet into family food practices.

Group 3: Maintainers.

Women who became long-term 'maintainers' in relation to their weight and eating were likely to have had past experiences of highly successful weight loss or weight stability. This success was likely to have been achieved by following a diet given by a doctor or with a slimming club. Such diets would be likely to be long-term undertakings and to have resulted in a complete change of diet so that a situation of constant controlled eating continued even after dieting (to lose weight) had ceased. Such controlled eating practices would result in weight stability but may not *necessarily* lead to feelings of satisfaction with weight. In some cases 'weight stability' may mean the lowest weight that the women felt that they were able to achieve through controlled eating practices but such a weight might not be viewed as an 'ideal' weight. The ability to sustain controlled patterns of eating would

generally mean that women had some level of support from partners in relation to the practical and/or the ideological organisation of food and eating in the household. Women who became long-term maintainers would be likely to have accepted their level of maintained weight and to have adjusted their lives accordingly. For some women this might mean that their weight did not constrain their activities at all whereas for others constraints might be experienced. The following example is illustrative of this general type:

Teresa Browne.

Teresa had been conscious of being fat since her teens and had tried numerous diets, including some under medical supervision. She finally concluded that she had a slow metabolism which meant that eating a relatively small amount of food would result in her putting on weight. To counteract this, she reduced her food intake substantially so that she ate only one meal a day, and virtually nothing else. She stuck to this strict food regime as rigidly as possible and noted that, by doing this, she was able to maintain her weight at a stable level. The weight that she stabilised at was not what she felt to be an 'ideal' weight. Indeed, she still felt conscious of being fat. Nevertheless, she accepted this level of weight as the lowest that she could achieve and intended to continue with controlled eating practices in order to maintain it. She put on a lot of weight during her pregnancy due to, what she saw as, inappropriate advice. However, after the birth of her baby she reverted back to her pre-pregnancy eating behaviour with the aim of getting back to her 'normal' weight. Teresa's partner was not actively supportive of her eating practices. However, the way that food and eating was organised in the household meant that he was not

obstructive to her following a controlled pattern of eating. This was because the couple did not have a strong ideology of 'family' meals and although Teresa prepared all the food in the household they did not consume these meals together (except on Sundays) and did not see it as important that they ate the same types of foods at mealtimes.

The identification of these three 'types' of attitudes to weight and eating that fat women are likely to adopt in the longer-term is only intended as tentative given that information obtained in the interviews did not cover the topic of long-term outcomes. More research in this area is necessary before more conclusive statements about this can be made. Nevertheless, even though the identification of the three 'types' is preliminary, some discussion of the implications of these for medical professionals is possible. Where women are in contact with medical professionals and report a desire to lose weight, a thorough assessment of them in relation to these 'types' may be helpful in revealing the sort of advice or support that would be most appropriate in helping them to achieve long-term 'success'. Gathering information about women's social situation and their past history is crucial and this information would enable the medical professional to classify the women according to their present attitude, or their predicted long-term attitude, regarding their weight and eating and to give advice and support that was appropriate to this. For example, women who adopt, or who seem likely to adopt, an attitude to their weight and eating that can be seen as corresponding to the general type of 'fatalists', but who still want ideally to lose weight, need help and/or support that is appropriate to this 'type'. Such women are likely to be very overweight and to have had a history of unsuccessful dieting attempts. This is likely to make

it necessary that medical professionals give a large degree of support and encouragement to enable such women to feel optimistic about eventual 'success'. Additionally, women adopting, or likely to adopt, a fatalistic attitude to their weight and eating are likely to have a domestic situation that makes the employment of controlled eating practices particularly difficult. Medical practitioners need to examine the extent of these and to devise strategies for the patient whereby these can be overcome or minimised. The sorts of advice that medical practitioners can give which takes into account women's social situation have been discussed at length above.

## 6.6 TOWARDS A POSITIVE IMAGE FOR FAT WOMEN?

In the discussion so far I have concentrated on the 34 women whose feelings about their weight were connected to the amount that they weighed and their eating patterns. These women made up the great majority of the sample. I have noted that it is unsurprising that most of the fat women interviewed for this research had their feelings about their weight determined by the actual amount that they weighed and the action that they were taking to change this. However, I do not intend to imply from this that the association between weight loss and positive feelings about bodysize is something that should be unquestioningly accepted as 'right' or 'normal' for women. This association existed for most of the women in the study but this does not mean that it is necessarily a desirable association from the point of view of the women, or indeed, the wider society. The fact that the majority of the women in the study felt very negatively about themselves because they were fat and could only envisage feeling more positive about themselves if they

lost weight demonstrates the importance that physical appearance holds for women. It demonstrates that these women's perception was that their value was based on how they look rather than the sort of people that they are.

Physical appearance is largely a matter of chance and inherited factors and although we can modify our appearance we cannot change our basic features, at least not without the use of surgery. There is a common view that weight and bodysize, unlike other physical features, can be changed through diet. This is undoubtedly the case as the large number of 'success' stories to be found in the media and advertising material for particular diets confirm. Nevertheless, dieting attempts and maintenance are more difficult for those people who are genetically large (Cataldo, 1985). While dieting can enable fat people to lose weight, such people are unlikely ever to become thin. There is much evidence in the preceding chapters that some of the fat women in this study felt that they had to 'diet constantly' in order to achieve long-term slimness and the difficulties associated with long-term self-denial of food was seen as accounting for the failure of diets for many women. The evidence of this research and other literature indicates that the slim body that is associated with sexual attractiveness for women is one that many women are unlikely ever to be able to achieve for genetic reasons (Wooley and Wooley, 1979; Cataldo, 1985; Gilbert, 1989; Bovey, 1989). This does not mean that such women could not lose weight, but rather that they would be unlikely to lose sufficient weight that would enable them to have a positive body-image.

Thus, the association that many of these women held between positive feelings about their weight (or positive body-image) and the amount that they weighed is not a desirable state. It is a state that is demoralising and potentially has extremely negative consequences. It is demoralising because it means that the women's self-image is based on their appearance, over which they may have only limited control, rather then their personality, their ability, their attributes, their skills or the myriad other non-physical characteristics that go to make up a person. As such these women define themselves as objects whose only value is in appearance. Furthermore, because of this association and because the potential for the desired change may not be great, it may mean that women plunge further into negative feelings about themselves which, as the preceding chapters and existing literature have illustrated, may lead to a withdrawal from full participation in the social world (McBride, 1982). Such actions obviously have an impact on the wider society in which women live.

Given these factors, it would seem that a more appropriate attitude for many fat women to hold would be an acceptance of their bodysize. All the while fat women feel that the only way that they can feel positive about their bodies, and therefore to some degree about themselves, is by losing weight and becoming slim, they are subjecting themselves to long periods of unhappiness or discontent which can affect their lives to a greater or lesser degree. By accepting their size and breaking the association between positive feelings about weight and a slim body, fat women could be liberated from their negative self-image, from the constraints that they experience in their daily lives, and from long and

punishing dietary regimes. This is not to argue that fat women should not diet or attempt to lose weight. If fat women want to lose weight and are able to do so then, of course, this is their choice. Rather, what I am arguing is that fat women, whether dieting or not, need to be able to feel that their self-image and their participation in the social world is not dependent on their size. By achieving this, fat women would be able to make a choice of whether they want to diet or not because they would not feel that losing weight was the essential ingredient that would bring about their happiness through social acceptability. What I am arguing for, then, is that fat women should be able to feel acceptance of themselves as they are and not have their self-image and actions constrained by their appearance. The importance of breaking this link between negative body-image (or self-image) and fatness has been noted in much of the literature (McBride, 1982; Jenkins and Smith, 1987; Bovey, 1989) and has parallels in the more general literature on stigmatised conditions (Breakwell, 1986). It is part of a general view that people should be accepted for whom they are, not for how they look, and such a position is also well represented in feminist literature (Greer, 1971).

In order to examine how the association between bodysize and body image can be broken it is necessary to examine the mechanisms that lead fat women to make this association. I have noted throughout this thesis that the reason why fat women generally feel dissatisfied with their size is because sexual attractiveness is seen as being of primary importance to women and one of the central tenets of the cultural ideal of sexual attractiveness is slimness (Coward, 1984). Thus fat women are likely to feel, to some degree, alienated from society because they do

not fulfil the cultural ideal of how women should look. Here I want to examine in more detail the mechanisms that bring about the stress on physical appearance for women in general and the application this has for fat women. I will then go on to examine what the possibilities are for change so that fat women could feel positive about themselves without necessarily losing weight.

Many feminist writers have argued that the emphasis placed on women's physical appearance rather than on non-physical attributes is a symptom of the patriarchal society in which we live. This literature has been discussed in chapter one but I will recapitulate the main points here. It is argued that because we live in a patriarchy, men hold positions of power in society and women do not. This has meant that, first, men can allocate to women the roles and behaviour expected of them (Sichtermann, 1986) and secondly, that women will accede to this because they need male approval both materially and emotionally (Cline and Spender, 1987). The mechanism that underpins the patriarchal system is the process of socialisation where, it is argued, women learn the roles, attitudes and behaviour befitting their position as subservient to men (Eisenstein, 1984). This process is held to be so effective that it is sufficient to uphold the patriarchal system. However, in rare cases where it does fail, force from individual men or from the structures of patriarchal society ensures its continuance (Cline and Spender, 1987). One of the central lessons of socialisation is the importance of physical appearance for girls and women. Girls learn from an early age that it is essential that they conform to prevailing standards of 'attractiveness' (Greer, 1971; Sharpe, 1976). They conform to this, first, because their socialisation has taught them that this is

right, secondly, because they will be rewarded by male approval and, thirdly, because this will ensure that they 'get' and 'keep' a man and thus benefit materially. It is argued that the prevailing standards of attractiveness at any given time reflect and reinforce the images that patriarchal society has of women and the roles that they are expected to play. For the last 30 years the prevailing standard of attractiveness has encompassed slimness and this, it is argued, amounts to a cultural ideal of attractiveness for women (Coward, 1984).

The arguments put forward by these femininst writers outline quite clearly the process whereby fat women arrive at the position of equating their self-esteem with their bodysize. Indeed, in their analysis, no other outcome is possible and no opportunities for change appear to exist: patriarchal society determines the roles and spheres allocated to women and one of its demands is that women conform to male notions of physical attractiveness. The process of socialisation or, where this fails, force, ensures that women conform to this. In this scheme women appear to be virtually powerless to do anything to change this.

While there is much evidence that women's position in society is governed by patriarchy and I would not want to dispute this, I would argue that the above account may give too pessimistic a view of women's position and the opportunities for change. Over the last forty years women's lives have changed markedly and some of these changes have resulted in increased independence for women. Changes in educational opportunities (Beechey, 1986), in the availability of contraception, the social acceptability of divorce and in the benefits system (Allan, 1985) have all contributed to the ability of women to live independently of men. While such changes have not brought about an *overall* change in the

balance of power between the sexes in that women are still viewed and treated as being of inferior status to men (Beechey and Whitelegg, 1986), nevertheless some changes in the *nature* of that balance of power has occurred.

The important point here is that a change in women's position has occurred and that these changes have led to greater independence, albeit of a limited nature, for many women. Obviously changes have affected some groups of women more than others, with middle-class women benefitting more than working-class women. The identification of these changes, and the fact that these changes have operated to some extent in women's interests, demonstrates the potential that there is for change to occur in the interests of women in patriarchal society. The feminist literature outlined above implies that change that benefits women could not occur because patriarchal society would not allow it. However, this is not the case. Change in any power relationship can occur but only as a result of negotiations and power struggles. Such changes that occur are likely to be compromises: the more powerful group will aim to grant as little change as possible and the less powerful group will seek to gain as much as possible. This process can be seen to have occurred over the last 40 years as women became more dissatisfied with their position at home and demanded greater participation in the public world (Friedan, 1965). The rise of the Women's Liberation Movement can be seen as a result of this dissatisfaction and as a contributory factor in women having some of their demands met (Mitchell and Oakley, 1986). The compromises that patriarchy has made have given some women greater independence, but these have not led to an overall change in women's position of disadvantage in relation to men. These changes, then, were

likely to have been the minimum that patriarchy could grant while still maintaining its position of power. While such changes may be limited and invariably not a threat to the maintenance of patriarchy this at least gives some scope for examining the possibilities of change in the stress placed on women's physical appearance and, in particular, in relation to fat women.

While many changes have occurred in women's position over the last 40 years, the emphasis placed on women's physical appearance has been very resistant to change. It still seems that most men evaluate women on the basis of their physical attractiveness and that most women assess themselves, and other women, in a similar way. There is much evidence, as has been discussed in chapter one, of women's pre-occupation with their, and other women's, appearance and of men's categorisation of women in this way (Coward, 1984; Bovey, 1989). It is argued that much of the sexism that women experience is a reflection of this (Measor, 1983; Cunnison, 1989). This stress on women's physical appearance, then, can be seen as one of the central pillars of patriarchy in that it defines women as objects whose primary value is in how they look, not who they are or what they can do. It is important to ask why this emphasis on women's physical appearance has persisted in the face of other changes that have occurred in women's lives and why, even with the active Women's Liberation Movement of the 1960's and 1970's, women seem to have been unable to move away from this objectification of their selves. By examining this issue, it should be possible to identify what, if any, scope there is for change.

The power of tradition has an important role to play in the persistence of oppression. Powerful groups in society that oppress

other, less powerful, groups build up an ideology about such groups to justify their rule over them. Such an ideology usually justifies the enforced dependence of one group on another. Where groups experience a long history of oppression, the ideology that justifies this is transmitted from generation to generation in the form of attitudes and strongly held beliefs about the nature of such groups of people which are seen as 'truths'. Such attitudes and beliefs cannot change overnight. Even when the oppression experienced by subservient groups lessens, tradition ensures that the dominant group's attitudes and beliefs persist at some level. A clear example of this is the case of the racism experienced by black people living in this country (Bryan, Dadzie and Scafe, 1985). There are parallels to be drawn between this and the experiences of women in patriarchal society.

The oppression of women has occurred as a result of the alleged inferiority of women in relation to men and their enforced dependence on them. The ideology that women are 'naturally' dependent on men has been used to justify this and specific attitudes and beliefs about the nature of women have arisen from this ideology. While it is not possible to state precisely where the emphasis on women's physical appearance originated it seems likely that it has arisen from this dependence relationship. The exclusion of women from the public sphere (which is equated with power) and their relegation to the domestic sphere (which is equated with lack of power) has meant that most avenues of power have been closed off for women. They have traditionally had little or no access to power on their own, only through men. This has meant that women have had to gain male approval to have access to material necessities and benefits. Precisely because most avenues of power and

independent action have been closed off to them, one of the few areas in which they can achieve such male approval is through their appearance. Indeed, it is noted that an emphasis on women's physical appearance is almost inevitable where women are dependent on the work and status of men (Schreiner, 1978). Precisely why physical appearance has become a crucial factor in achieving male approval is unclear but it seems likely that this is related to women's enforced inability for independent action which has relegated them to being objects or appendages of men. The definition of women as objects means that they have been judged by their appearance, not by their being, and as a result those that 'look the best' have reaped the most benefits by being chosen by men. Additionally, men too have gained status by obtaining the most attractive 'objects' (women). Thus the emphasis on women's physical appearance has been crucial for women in order to obtain material benefits because it is one of the primary attributes that men, as the dominant group, have defined as important in women.

While women's lives have changed over the last 40 years so that they are not as dependent on men as they once were for material benefits, a significant reduction in the emphasis on women's physical appearance has not occurred. Feminist literature arising out of the Women's Liberation Movement from the 1960's onwards tried to encourage women away from this emphasis and as a result to force men to change too. Women were advised to stop conforming to stereotypical images of attractiveness but this appearred to have no significant effect (Friedan, 1965; Greer, 1971; Orbach, 1978). Part of the reason for this may be the overt sexism and power of patriarchal society that does not allow women to move away from this image. However this is likely to be

compounded by persistent sexist attitudes towards women that survive, sometimes unconsciously, in the face of women's proven ability and worth as independent and active beings and not as mere objects. Additionally it needs to be noted that while women do tend to play a far more active role in the public world than they did 40 years ago, their lives are still severely constrained by a lack of access to power. While women have the capacity to be economically independent of men, the material benefits associated with living with men are still far greater for most women. Evidence of this is the large number of single women living at or near poverty levels and the probability of re-marriage after divorce (Allan, 1985). Furthermore, access to alternative avenues of power are still severely restricted for most women. Thus, most women still need to gain male approval to gain material benefits or status and prestige and men are still in a position to demand this.

Thus, while change benefitting women in patriarchal society is possible, providing it does not affect the overall balance of power between the sexes, such change is more likely to occur in areas where discrimination against women is most overt and noticeable (such as in the law, in occupational status and earnings). Changes in the attitudes and underlying beliefs that have been built up to justify women's history of oppression are less likely. Changes in attitudes relating to oppressed groups are almost always very slow. The emphasis on women's physical appearance is likely to be one of the areas subject to slow change given that it has been a central feature in the history of patriarchal control over women. Additionally, women's lives have not changed so dramatically to force a change in these attitudes.

The potential for change in the emphasis on women's physical appearance, then, does not seem very great. The onus has to be on women to fight for change given that patriarchal society, which operates in the interests of men, is unlikely to grant such change voluntarily. It seems that there are two possible strategies that women could employ in order to try to change this situation, each of which is beset with its own constraints. The options are: first, that women demand a change specifically on the emphasis that is placed on their physical appearance with the force that they have demanded other changes in the past, such as, rights to contraception and abortion, equal opportunities in education and employment, equal pay, and equality under the law; or, secondly, that women demand changes on other fronts unrelated to the emphasis placed on their physical appearance so that they achieve greater equality with men with the eventual outcome that the stress on their appearance declines. Both of these strategies are beset with the constraints that arise for women living in a patriarchal society where women have only limited power for action and where change is likely to be granted only if it does not affect the overall power structure.

The two strategies outlined above are reflected in the literature relating specifically to fat women. There is a large literature that focuses on the first of these possibilities as a strategy for enabling fat women to challenge the cultural ideal that equates attractiveness with slimness for women. Much of this literature has come from the Fat Women's Liberation Movement or people allied to the position of this group and has been discussed in chapter one (Wooley and Wooley, 1979; Schoenfielder and Wieser, 1983; Jenkins and Smith, 1987; Bovey, 1989). Most of this literature is feminist but it does not see the problems

experienced by fat women as being reducible solely to the patriarchal nature of society. More important to their analysis is the notion of a 'fat-hating' society (Schoenfielder and Wieser, 1983). It is argued that the result of the societal hatred of fatness that women in particular experience because of the emphasis placed on their physical appearance, is that fat women experience feelings of low self-worth and alienation from mainstream society. Writers from the Fat Women's Liberation Movement urge women to challenge patriarchy and the fat-hatred that they experience by refusing to conform to the cultural ideal of slimness. They argue that fat women should take pride in their size and should give up punishing themselves through constant dieting attempts and non-participation in the social world. Some feminist literature has also stressed the importance of women's refusal to conform to the cultural ideal of slimness as a strategy for changing this emphasis on women's physical appearance and their consequent objectification. Much of this literature comes from radical feminism and was more common during the 1960's and 1970's (Greer, 1971).

The second strategy of diverting the focus away from fat women's physical appearance onto their achievements and capabilities has received less attention in the literature. There is a considerable literature examining the importance of women attaining positions of high status, prestige and power in society in order to achieve equality with men, but this does not focus specifically on the effect that this may have on the current emphasis on fat women's physical appearance. However there is some literature that discusses the inadequacy of the above strategy of women's refusal to conform to stereotypical images of attractiveness and this discusses alternative strategies (Sichtermann,

1986; Haug, 1987). It is argued in this literature that non-conformity to accepted norms of attractiveness in reality means proposing alternative images of attractiveness for women. Certainly this is the case with the Fat Women's Liberation Movement whose aim is to propagate the view that fat is beautiful. Some of the feminist literature too, by proposing non-conformity to one image, the dominant one, proposes conformity to an alternative one. The problem with these approaches, their critics argue, is that they still place the focus on women's appearance. Thus, they argue, just as patriarchal society focuses on women's appearance so too do these alternatives and this has the effect of re-inforcing the importance of physical appearance for women. While this is far from being the intention of this literature, it is argued that this is the outcome. The focus means that physical appearance is still placed in the central position of primary importance to women and as such, still reduces them to objects. As an alternative to this, it is suggessted that if women were to 'channel their energies in new directions rather than concentrating exclusively on their deficiencies' (Haug, 1987:130) then this would present an opportunity to reduce the emphasis on physical appearance and to focus on women as active beings rather than objects.

There is no question that a move away from the current emphasis on women's physical appearance is crucial for fat women. However, there are no straightforward answers regarding how fat women could achieve this. Each strategy outlined above has its drawbacks and each is beset by the constraints that arise from living in a patriarchal society. For either strategy to succeed demands the acquiesence of men and of

society. For alternative images of women's attractiveness to become acceptable it is necessary that the majority of women and the majority of men accept them too. The achievement of this is likely to be a very slow and hard process: images of attractiveness for women, as has been discussed in chapter one, are controlled by men, are reinforced by the media and the fashion, beauty and slimming industries, and are condoned and accepted by the vast majority of women. Furthermore, the achievement of this end might not result in diminishing the importance of physical appearance for women and therefore might substitute the social acceptability of fatness for the social unacceptability of another physical characteristic which might be equally hard to live up to. However, for women to achieve recognition in other areas of their lives and so to divert attention away from their appearance is also not a straightforward strategy. Women cannot achieve such recognition on their own. Men hold positions of power in society and define what areas of life confer status and prestige. Access to such areas has been limited for women because these have been the domain of men. Furthermore, even where women have achieved positions of high status they have still not achieved the prestige afforded to men in similar positions This is because society has remained patriarchal and high status has to be conferred by men on women. Additionally, it might not be possible for fat women in particular to achieve high status positions in society given that there is some evidence that they are discriminated against occupationally because of a societal dislike of fatness (Allon, 1980).

The prospects for fat women, as a group, achieving a positive self-image unrelated to their physical appearance seems unlikely at the

present time. Nevertheless, this does not mean that it is impossible for individual fat women to raise their self-esteem without losing weight. Fat women, like all other members of society, are not just victims of the structure of society but have the capacity to act. Although such actions must be within the constraints imposed by society, which for women are very restrictive, this does not make actions to modify their position impossible. I would argue that the way forward for fat women is to aim to achieve positive feelings about themselves as individuals through actions that focus on their characters and their abilities, not on their appearance. By focussing on themselves as people rather than objects the raising of self-image on an individual basis may be possible. Such a strategy is not an easy one to undertake given the constraints imposed by a patriarchal and fat-hating society, but until society changes this appears to be the only viable option open to fat women. Such a strategy may also be a way forward for women in general who experience negative self-esteem as a result of a perceived failure to conform to cultural ideals of physical attractiveness for women and may be a way of breaking, on an individual basis, the association that they hold between their appearance and their self-esteem. This strategy does not deny the necessity of society changing to view women as people rather than objects. Indeed, I would argue the fight to change this emphasis on women's physical appearance is one that all women should embark on. This strategy is, therefore, intended as a practical short-term strategy for fat women in the present climate.

## 6.7 CONCLUSION

In this chapter I have analysed and classified the movements of the women as they passed through the stages of pre-, during and post-pregnancy in terms of the two major aspects of this research: feelings about weight and experiences regarding eating. The general pattern that emerged for the three periods was that, before pregnancy, the majority of the women in the study experienced negative feelings about their weight and uncontrolled eating patterns. However, during pregnancy there was a shift towards controlled patterns of eating and a shift for some women to more positive feelings about their weight. The move towards controlled patterns of eating continued after pregnancy but there was a revertion to negative feelings about weight for most women. The actual *movements* of the women between the groups were complex and were dependent on the women's experiences of particular events occuring during the three phases of before, during and after pregnancy. The variables identified as important in leading to a change in feelings about weight were: the amount of weight gained or lost during those periods; changes in the social image of women making being fat more or less acceptable; medical and lay advice; and, desirability of pregnancy, enjoyment of motherhood and general emotional well-being. The variables identified as important in leading to a change in experiences regarding eating were: changes in diet resulting from emotional well-being associated with pregnancy or early motherhood; changes in diet to alleviate the physical effects of pregnancy or to enable breast-feeding; advice; changes in the practical or ideological organisation of food and

eating; and, food restriction as a result of self-perception of high weight-gain or to prevent high weight-gain.

In general, it appeared that pregnancy had the potential to bring about changes in perceptions about weight and experiences regarding eating. Some of these changes continued after pregnancy, at least in the short-term. However, for many of the women pregnancy and the early weeks of motherhood were periods which allowed for different feelings and experiences regarding weight and eating which were only short-lived. For most of the women, a return to something approaching their pre-pregnancy feelings about weight and experiences regarding eating in the longer-term seemed likely. These feelings and experiences were related to the amount that the women weighed so that the majority of the women desired to achieve or maintain slimness as they had done before pregnancy. The major reason for this is likely to be the stress placed on women's physical appearance which puts great social pressure on women to be slim.

An analysis of post-pregnancy outcomes in terms of feelings about weight and experiences regarding eating revealed that, for the majority of women in the study, eating practices were connected to feelings about weight. It emerged that the majority of the women could only feel positive about their bodies, and consequently to some degree about themselves, if they were slim and the way to achieve this slimness was seen to be through the employment of controlled eating practices. After pregnancy, then, the majority of the women either employed controlled patterns of eating in order to achieve or maintain positive feelings about their weight or experienced negative feelings about their weight because they felt unable to change their eating practices which were

viewed as the only way that they could feel more positively about their weight. I noted that this connection between actual weight (amount) and feelings about weight is unsurprising given the emphasis placed on women's physical appearance in a patriarchal society.

In an ideal world, women would be able to feel positive about themselves as people, regardless of their appearance, rather than as objects. However, for most women this is an unrealistic objective because of the social, practical and emotional benefits that conforming to cultural notions of attractiveness (i.e. slimness) brings. Indeed, only one woman in this study seemed to have achieved this aim. Given this, I have examined some of the ways that medical professionals could help women towards the goal of slimness and positive body image. Help, support and advice from medical professionals regarding weight-loss needs to take women's social situation into account and the information gained from the interviews revealed the areas of difficulty in respect of dieting for many women. The focus on ways of achieving positive body image through dieting was intended as a short-term solution. The longer-term solution, and one that all women need to participate in, needs to be to fight for greater equality with men and recognition of themselves as individuals, not objects. Only through this can the focus on women's physical appearance, and the emphasis on slimness as an ideal, diminish. The achievement of this aim, however, is as yet a long way off.

## APPENDIX 1

Pregnancy And Childbirth Study Questionnaire 1
(To be completed after the life-history chart).

I'd like to start by asking you some specific questions about your eating and weight in the period before you became pregnant (this time).

1. Can you tell me how you felt about your weight and size before you became pregnant? Were you satisfied with it?
(If yes, go on to question 3)

2. Why do you think you felt this way about your weight? What in particular made you unhappy about it?
Probe;
(i) Particular situations, occassions or people that made her feel worse about her weight.
e.g,
Buying clothes/communual changing rooms.
Being with thin people
Comments people make

(ii) Any things she felt prohibited from doing because of her weight.
e.g,
Swimming, dancing etc.
Feeling of being able to do more things if slimmer.

(iii) Feelings of unattractiveness.
e.g,
effect of media portrayal of slim people.

3. Were you trying to lose weight at this time?
(If YES;
(i) How was weight loss being attempted.

(ii) What was desired weight.

4. Can you tell me about your eating before you became pregnant? The sorts of foods you enjoyed eating, the amounts you ate and when you ate, that sort of thing?
Probe;
(i) Average daily eating pattern - what food is eaten and who prepares it as well as where, when and with whom it is eaten.

(ii) Average weekly alcohol consumption.

(iii) Favourite foods and drinks and how often consumed.

(iv) Effect of particular moods (e.g, lonliness, anxiety) on consumption.

(v) Eating 'binges' (i.e. if interviewee had bouts of eating when she felt she couldn't stop). When and with what foods these occurred.

(vi) Whether different quantities are eaten when eating in company compared to eating alone.

(vii) Who chooses what is cooked at mealtimes.

(viii) Views of mealtimes as 'family occassions'

(ix) Whether eating patterns were different to parents.

5. Can you tell me what foods you think of as being good for you?

6. How did you feel about your eating before you were pregnant? Did you feel you were eating a good diet or did you feel that you ought to change what you ate in some way?
Probe;
(i) Any foods that the interviewee felt should be consumed less/more and why.
(if none, go on to question 7).

(ii) Why this wasn't done.

7. Can you tell me what you used to associate with the words food and eating?
(if no response) Probe;
For example, would it make you think of eating particular favourite foods and of that being something you enjoy or would you think of having to prepare and cook food and that being a bit of a chore.

8. Can you tell me what your involvement was with the shopping, cooking and preparing of food at this time?
Probe
(i) Feelings about this and if this influences feelings about food and eating (e.g, would interviewee enjoy it more if she didn't have to cook it etc.).

I'd now like to ask you the same sort of questions about your eating and weight since you've been pregnant.

9. Can you tell me how you feel about your weight and size since you've been pregnant? Do you feel differently about it than before you were pregnant?
Probe;
(i) Any areas identified in question 2.

ii) Feelings about the amount of weight put on in pregnancy.

10. Have you been trying to diet or restrict your weight gain since you've been pregnant?

11. Can you tell me about how you've been eating since you've been pregnant and any changes that you've made? Can we go through a typical day like we did just now for before you were pregnant? Perhaps it would be easiest if you tell me what you had to eat yesterday.
Probe;
(i) Any cravings for certain foods.

(ii) Any aversions to certain foods.

(iii) Any change in amounts eaten.

(iv) Any changes from the general pattern of eating identified in question 4.

(v) Reasons for changes.

12. Are you satisfied about the way you've been eating since you've been pregnant or is there anything you feel you'd like to or should change if you could.
If DISSATISFIED:
(i) Why interviewee feels she should eat differently.

(ii) What foods she feels she should eat more/less of.

(iii) Why this hasn't been done.

13. Do you associate different things with the words food and eating since you've been pregnant?

14. Has your involvement in the shopping, preparing and cooking of food changed since you've been pregnant?

15. Has your doctor (G.P.) or midwife or a doctor or midwife at the hospital ante-natal clinic made any comments or given you any advice about your weight or eating?
If YES;
(i) Comments/advice given and by whom.

(ii) Any booklets or leaflets given.

(iii) Referrals made.

(iv) Interviewee's thoughts and feelings about this and whether advice has been followed.

16. Have your family and friends given you any advice about your weight and eating since you've been pregnant?
If YES;
(i) What advice given and by whom.

(ii) Interviewee's thoughts and feelings about this and whether it has been followed.

If interviewee has had previous pregnancies:
(if not go on to question 18)
17. Can you tell me about your previous pregnancy(ies). Did you have similar experiences to this pregnancy regarding your weight and eating?
Probe:
(i) Amount of weight put on in previous pregnancies and feelings about it.

(ii) Attempts to restrict weight gain in previous pregnancies.

(iii) Cravings or aversions in previous pregnancies or any distinctive eating patterns.

(iv) Advice/treatment from medical professionals.

I'd now like to go on to ask you some general questions about your pregnancy.

18. Can you tell me how you felt when you first found out you were pregnant?
Probe;
(i) At what stage pregnancy was confirmed.

(ii) If pregnancy was planned.

(iii) Reactions of husband/partner.

(iv) Reactions of relatives/friends.

19. Can you tell me what being pregnant up to now has been like for you? Have you enjoyed it?
Probe the following areas;
(i) Good and bad things about it.

(ii) If it has been as expected.

(iii) Physical well-being.

(iv) Worries about the pregnancy.

(v) Effect on employment.

(vi) Effect on relationship with husband/partner and children.

(vii) Effect on social life/leisure activities.

(viii) Any other changes.

(ix) Stressful life events.

(x) Views about the medical treatment received during pregnancy.

20. How do you feel about the actual birth of your baby and about becoming a mother? Do you have any worries about this?
Probe;
(i) Type of birth anticipated.

(ii) Length of stay in hospital.

(iii) Breastfeeding planned?

(iv) Arrangements at home after leaving hospital.

21. Have you talked to anyone about any worries you've had about your pregnancy or the birth of your baby?
Probe;
(i) G.P., midwife, obstetrician, mother, spouse, friends.

(ii) What response has been given.

(iii) Whether this has been helpful.

I'd like to finish by just asking you a few questions about your domestic arrangements now and your plans for when you've had your baby.

22. Can you tell me first how you and your husband/partner organise the things that have to be done in the home like housework, cooking and washing? Who does what?
Probe;
(i) Satisfaction with these arrangements.

(ii) Whether interviewee thinks this will continue after the baby is born.

(iii) If the domestic arrangements are different to those of parents.

23. How involved do you think your husband/partner will be with looking after the baby?
Probe
(i) The sorts of things the interviewee thinks he will/won't do.

(ii) Satisfaction with this.

24. Can you tell me what your plans are for when you've had your baby? Are you planning to go back to work/get a job?
If NO;
(i) Any plans or thoughts about getting a job in the future.

(ii) Expectations of being a full-time mother.

(iii) Perceived satisfaction with this.

If YES:
(i) Arrangements for childcare.

(ii) Expectations of being a working mother.

(iii) Perceived satisfaction with this.

25. Is there anything else you'd like to add to the things we've talked about?

26. Is there anything you want to ask me?

## Pregnancy And Childbirth Study Questionnaire 2

I'd like to start by asking you a few questions about the birth of your baby and how you've been feeling since then.

1. Can you tell me about the birth of your baby? What was it like?
Probe
(i) If it was like it was expected to be.

(ii) Medication used.

(iii) Any complications.

(iv) Feelings about treatment received from medical personnel involved.

(v) Feelings about the labour and birth.

2. What about the time you spent in hospital after your baby was born. What was that like?
Probe
(i) Physical and emotional well-being (to include post-natal depression/blues).

(ii) Length of stay in hospital.

(iii) Feelings about the baby.

(iii) Feelings about the practical day-to-day care for the baby.

(iv) Breastfeeding.

(v) Feelings regarding the hospital staff.

(vi) Spouse, existing children and kin reactions.

3. Can you remember how you felt about coming home from hospital with your baby?
Probe
(i) Feelings on arriving home.

(ii) Feelings about being at home and caring for the baby.

(iii) Support at home (spouse, kin, friends?).

(iv) Support from medical professionals.

(v) Reactions of spouse and existing children.

(vi) Physical and emotional well-being.

4. Can you tell me how you feel now about your day-to-day life with your baby?
Probe
(i) Physical and emotional well-being.

(ii) Feelings about motherhood.

(iii) Feelings about the baby.

(iv) Feelings about loss of pre-pregnant life-style.

(v) Effect on marital relationship and relationship with existing children.

(vi) Social life since baby's birth.

(vii) Practical and emotional support from spouse and feelings about this.

(viii) Contact and support from kin and friends.

(ix) Contact with others in a similar situation.

(x) Feelings about practical day-to-day care of the baby. (note here if breastfeeding).

5. When I came to see you before we talked about your domestic arrangements regarding housework and cooking and things like that, do you remember? Can you tell me, has anything changed in these domestic arrangements since you've had the baby?
Probe
(i) More/less/same level of domestic work done by spouse.

(ii) Perception of permanancy of any changes.

(iii) Satisfaction with the domestic arrangements.

6. We also talked about your plans for employment after you had your baby when I came to see you last. Have you changed your mind about this at all?
If YES, probe
(i) Reasons for change.

(ii) Satisfaction with this.

If NO, probe
(i) Feelings about plans now the baby is born.

(ii) Changes in feelings of perceived satisfaction identified in questionnaire 1.

I'd like to go on to ask you a few questions now about your eating and weight since you've had your baby.

7. Can you tell me how you feel about your weight and size now that you've had your baby? Are you satisfied with it?
Probe
(i) Any changes in satisfaction/dissatisfaction identified from questionnaire 1.

(ii) Any new situations, occassions or people that give rise to negative feelings about weight.

8. Do you weigh more now than before you were pregnant?

9. Are you trying to lose weight now?
If YES, probe
(i) How weight loss is being attempted.

(ii) desired weight.

10. Have any of the medical professionals that you've come into contact with made any comments or given you any advice about your weight or eating since you've had your baby?
Probe
(i) Hospital doctors or midwives during post-natal hospital period.

(ii) G.P. or community midwife.

(iii) Health Visitor.

(iv) Referrals.

(v) Thoughts and feelings about comments/advice and whether it has been followed.

11. What about your husband/partner and your family and friends. Have they made any comments or given you any advice about your weight or eating since you've had the baby.
Probe
(i) Husband/partner

(ii) Kin and friends.

(iii) Thoughts and feelings about this.

12. Can you tell me how you've been eating since you've had your baby?
Probe
(i) Average daily eating and drinking pattern - what food is eaten and who prepares it as well as where, when and with whom it is eaten.

(ii) Any changes from eating pattern in pregnancy identified in questionnaire 1.

(iii) Any changes from eating pattern before pregnancy as identified in questionnaire 1.

(iv) Reasons for any changes.

13. Are you satisfied about the way you've been eating since you've had your baby, or is there anything you feel you'd like to or should change if you could?
If <u>DISSATISFIED</u>, probe
(i) Why interviewee feels she should eat differently.

(ii) What foods she feels she should eat more/less of.

(iii) Why this hasn't been done.

14. When I came to see you before, we talked about your feelings about food and eating in terms of your enjoyment of food and your involvement in its preparation. Can you tell me if you feel any differently about those things now?
<u>Probe</u>
(i) Any changes from the areas identified in questionnaire 1.

15. Is there anything else you'd like to add to the things we've talked about.

16. Is there anything you'd like to ask me.

APPENDIX 3: LIFE HISTORY CHART

| YEAR | AGE | PLACE | HOUSING TENURE/TYPE | HOUSEHOLD MEMBERS | EDUCATION/ OCC. | MEALTIMES/ FOOD | WEIGHT | DIETS |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

## APPENDIX 3

### Letter For Interviewees

Department of Sociology and Social Policy,
University of Southampton,
Southampton.
SO9 5NH

Dear

I am doing a study at Southampton University looking at women's experiences and feelings about weight and eating before, during and after pregnancy. For this study I am visiting about 40 women and talking to them about their feelings about food and weight as well as their experiences of being pregnant and having a baby.

I have been given your name by the hospital where you are having your ante-natal treatment who are co-operating with this study. I am writing to you to ask if you would be willing to talk to me about your experiences. I do hope that you will feel able to do so. I enclose a post-card and I would be grateful if you would complete and return this to me letting me know if you would be willing to talk to me or not.

If you are willing, I would like to come and talk to you, in your home, sometime after the 30th week of your pregnancy and again about six weeks after your baby has been born. Each session will probably last about one hour and will be very informal. Anything we talk about will of course be treated in the strictest confidence. When I receive your post-card, and if you are willing to take part, I will contact you to arrange a suitable time for me to come and see you.

I do hope that you will feel able to take part in my study and I look forward to hearing from you soon.

Yours,

ROSE WILES

## APPENDIX 4

### Letter For Interviewees' G.P.'s

Department of Sociology and Social Policy,
University of Southampton,
Southampton.
SO9 5NH

Dear

I am doing a study at Southampton University looking at the social aspects of obesity in pregnancy. To do this I will be inteviewing about 40 women and talking to them about food and weight as well as their experiences of being pregnant and having a baby.

I am basing this study in the Southampton area and using the records kept at local hospitals to identify women eligible to take part in the study. I would like to approach the following of your patients to ask them to participate:

I would be grateful if you could inform me if you have any objections to my contacting these patients. If I do not hear from you within a week I will presume you have no objections to my inviting the above named patients to participate in the study.

Yours,

ROSE WILES
(Post-Graduate Research Student, Southampton University).

## APPENDIX FIVE

### Outline Of The Interviewees

1. Christine Barnes
Age: 17. Marital status: Married. Number of previous pregnancies: 1.
Most recent employment: Never been in paid employment.
Partner's employment: Sales assistant.
Housing: Council flat in urban area.
Weight History
Christine recalled being unconcerned about her weight until she was about 13 years old. She put on a lot of weight when she was expecting her first child and weighed considerably more after this pregnancy than before. She atempted to diet after the pregnancy but found the weight hard to lose. She was dissatisfied with her size and wanted to lose weight. She attributed her size to her food consumption.
Weight before pregnancy: 83kg.
Weight at 30 weeks pregnant: 100kg.
Weight six weeks after childbirth: 86kg.

2. Pauline Barton
Age: 33. Marital status: cohabiting.
Number of previous pregnancies: 1 (child adopted).
Most recent employment: shop assistant. Partner's employment: retired.
Housing: council house in urban area.
Weight History
Pauline felt that she had always been fat but had never been concerned about it. She was put on numerous diets during childhood but after leaving school she had not dieted again. She put on a lot of weight during her first pregnancy which she was unable to lose. However, she did lose a lot of weight after her separation from her second husband as a result of a change in diet. She accepted her size and expressed no dissatisfaction with it. She did not attribute her size to any particular factors.
Weight before pregnancy: 138kg.
Weight at 30 weeks pregnant: 107kg.
Weight six weeks after childbirth: 103kg.

3. Lucy Bowles
Age: 29. Marital status: married. Number of previous pregnancies: 2.
Most recent employment: catering assistant.
Partner's employment: taxi driver.
Housing: Council house in suburban area.
Weight History
Lucy noted that she had felt dissatisfied about her weight since she was about 15 and had dieted almost constantly since then. Weight gain during her pregnancies was not a problem and in fact she noted that she had a tendency to lose weight towards the end of her pregnancies. She felt that the major cause of her size was picking at snack-type foods in between meals.
Weight before pregnancy: 83kg.
Weight at 30 weeks pregnant: 90kg.
Weight six weeks after childbirth: 69kg.

4. Teresa Browne
Age: 24 Marital status: married. Number of previous pregnancies: 0.
Most recent employment: nurse. Partner's employment: mechanic.
Housing: council house in urban area.
Weight History
Teresa noted that she felt unhappy about her weight from the age of 12 and had tried numerous diets since then most of which had been unsuccessful. She felt that she had a slow metabolism and that this was the cause of her size and so she tried to eat as little as possible. In general she limited herself to one meal a day. She was self-conscious and dissatisfied with her size.
Weight before pregnancy: 80kg.
Weight at 30 weeks pregnant: 104kg.
Weight six weeks after childbirth: 87kg.

5. Nina Clarke
Age; 23. Marital status: cohabiting. Number of previous pregnancies: 1.
Most recent employment: bar steward. Partner's employment: tree feller.
Housing: council house in suburban area.
Weight History
Nina felt that she had always been 'big' but she was not unhappy about this until her first pregnancy when she put on a lot of weight. She found this weight very hard to lose and had just managed to get it down when she became pregnant again. She was not dissatisfied with her size immediately before the current pregnancy because she had dieted successfully and achieved weight loss. She attributed her size before dieting to overeating during her previous pregnancy.
Weight before pregnancy: 90kg.
Weight at 30 weeks pregnant: 105kg.
Weight six weeks after pregnancy: 104kg.

6. Jane Clinton
Age: 35. Marital Status: cohabiting. Number of previous pregnancies: 2
Most recent employment: cleaner. Partner's employment: lorry driver.
Housing: council house in suburban area.
Weight History
Jane noted that she had always been fat but had become most dissatisfied with her size during her teens when she went on a number of diets. She gave up dieting when she realised that she would have to diet for the rest of her life if she wanted to stay slim. Following this she began to accept her size and to eat exactly what she wanted to without worrying about its effect on her weight. She was not dissatisfied with her size. She attributed the cause of her size to be largely genetic.
Weight before pregnancy: 108kg.
Weight at 30 weeks pregnant: 110kg.
Weight six weeks after childbirth: 98kg.

7. Susan Crawford
Age: 25. Marital status: single. Number of previous pregnancies: 0.
Most recent employment: shop assistant.
Housing: living with her parents in their own house in a suburban area.

Weight History
Susan felt that she had always been 'big'. She lost a lot of weight following a serious motorcycle accident when she was 16 but put this, and more, on again while she was convalescing. This was because everyone 'spoilt' her by cooking her favourite foods and bringing her 'treats'. Her weight had been up and down following this and she had been on several diets. She was dissatisfied with her size and attributed it to her food consumption.
Weight before pregnancy: 90kg.
Weight at 30 weeks pregnant: 93kg.
Weight six weeks after childbirth: 90kg.

8. Sandra Crocker
Age: 25. Marital status: married. Number of previous pregnancies: 1.
Most recent employment: administration officer.
Partner's employment: office manager.
Housing: own house in a suburban area.
Weight History
Sandra felt that she had always been 'big' but had been able to control her weight up to the age of 16 because she participated in a lot of sporting activities. However, as a result of injury she withdrew from sport and gained a lot of weight which she was never able to lose. She dieted almost constantly following this although never very successfully. She put on quite a lot of weight during her first pregnancy and started a strict diet (with WeightWatchers) following this. She lost a considerable amount of weight before she got pregnant again and was as a consequence satisfied with her weight and size immediately before the present pregnancy. She attributed her pre-pregnancy weight to hereditary factors, a lack of exercise and overeating.
Weight before pregnancy: 82kg.
Weight at 30 weeks pregnant: 90kg.
Weight six weeks after childbirth: 96kg.

9. Linda Dobson
Age: 32. Marital status: married.
Number of previous pregnancies: 1 (miscarried)
Most recent employment: shop assistant. Partner's employment: electrician.
Housing: own house in urban area.
Weight History
Linda felt that she had become fat when she moved away from home at the age of 21. She first dieted when she was 23 and this was successful. She put on more weight after she got married but she did not feel too unhappy about this and had not dieted following her marriage. She was only marginally dissatisfied with her weight and size. She did not attribute her size to any particular factors.
Weight before pregnancy: 85kg.
Weight at 30 weeks pregnant: 91kg.
Weight six weeks after childbirth: 85kg.

10. Angela Downer
Age: 23. Marital status: married. Number of previous pregnancies: 1.
Most recent employment: sales assistant.

Partner's employment: electrical engineer.
Housing: own house in suburban area.
Weight History
Angela felt that she had become fat when she went to live with her grandmother after her parents' divorce. She attributed this to the change in diet. She attempted her first diet when she was 14 which was unsuccessful and her weight remained fairly stable from then up until the time of her first pregnancy. She put on a lot of weight during her first pregnancy which she was unable to lose although she made constant attempts to diet. She felt that the main difficulty prohibiting her from losing weight was that her husband's food preferences were for high-calorie foods. She was very dissatisfied and distressed about her weight and size.
Weight before pregnancy: 105kg.
Weight at 30 weeks pregnant: 113kg.
Weight six weeks after childbirth: 105kg.

11. Brenda Gray
Age: 25. Marital status: married. Number of previous pregnancies: 0.
Most recent employment: factory worker.
Partner's employment: self-employed labourer.
Housing: own house in a suburban area.
Weight History
Brenda felt that she had always been bigger than her peers and had always disliked this. She had been on many diets, none of which was successful in the long term. She was very dissatisfied and distressed about her weight and size which she attributed to overeating.
Weight before pregnancy: 95kg.
Weight at 30 weeks pregnant: 106kg.
Weight six weeks after childbirth: 110kg.

12. Rachel Hardwick
Age: 21. Marital status: married. Number of previous pregnancies: 0.
Most recent employment: clerical officer.
Partner's employment: factory worker.
Housing: own house in suburban area.
Weight History
Rachel had felt conscious of being fat since childhood and felt particularly unhappy about this during her teens when she attempted numerous diets. After her marriage she felt less unhappy about her weight and stopped dieting. As a consequence of this she felt that she put on more weight. She was marginally dissatisfied with her weight before the present pregnancy. She did not attribute her size to any particular factors.
Weight before pregnancy: 83kg.
Weight at 30 weeks pregnant: 91kg.
Weight six weeks after childbirth: 90kg.

13. Jenny Harris
Age: 16. Marital status: cohabiting. Number of previous pregnancies: 0.
Most recent employment: never been in paid employment.
Partner's employment: factory worker.
Housing: living with her boyfriend in her parent's rented house in an urban area.

Weight History
Jenny noted that she had been fat from an early age. She had been referred to a dietician when she was eight and she was put on a diet for several years although this was largely unsuccessful. She was referred back to the dietician when she was 14 but again this was not terrribly successful. She was only marginally dissatisfied with her weight and size. She tended to eat a lot of snack-type foods and she felt that this was a major factor that contributed to her size.
Weight before pregnancy: 103kg.
Weight at 30 weeks pregnant: 115kg.
Weight six weeks after childbirth: 106kg.

14. Susan Hartwell
Age: 29. Marital status: married.
Number of previous pregnancies: 5 (two of these ended in miscarriage and one in a stillbirth).
Most recent employment: factory worker.
Partner's employment: merchant seaman.
Housing: Council flat in an urban area.
Weight History
Susan noted that she had been fat since the age of seven and had been on numerous diets, all of which had been unsuccessful. She felt that the constant dieting had resulted in her being fatter than she would otherwise have been because they had the effect of slowing down her metabolism. In addition, she felt that her pregnancies also contributed to her weight gain. She was self-conscious about her weight and very dissatisfied with it. She attributed her size largely to metabolic factors.
Weight before pregnancy: 100kg.
Weight at 30 weeks pregnant: 130kg.
Weight six weeks after childbirth: 130kg.

15. Barbara Holmes
Age: 32. Marital status: married. Number of previous pregnancies: 3.
Most recent employment: catering manager.
Partner's employment: double-glazing installer.
Housing: own house in a suburban area.
Weight History
Barbara noted that she had been fat since her teens. She felt that she put on even more weight when she got married and that her job in catering probably contributed to her being fat. She put on a lot of weight during her first pregnancy which she found difficult to lose and she had dieted constantly since then. She felt that she had some success with weight loss but only initially. She was dissatisfied about her weight and size and she attributed it primarily to her food consumption.
Weight before pregnancy: 93kg.
Weight at 30 weeks pregnant: 98kg.
Weight six weeks after childbirth: 93kg.

16. Jackie Johnston
Age: 24. Marital status: married. Number of previous pregnancies: 2.
Most recent employment: factory worker.
Partner's employment: army private.

Housing: rented house in a suburban area.
Weight History
Jackie noted that she became fat during her first pregnancy and did not manage to lose this weight before becoming pregnant again. She had been on a number of diets following her second pregnancy but could not achieve long-term weight loss. She was dissatisfied with her weight and attributed her size to her food consumption and a result of her previous pregnancies.
Weight before pregnancy: 96kg.
Weight at 30 weeks pregnant: 100kg.
Weight six weeks after childbirth: 95kg.

17. Rosemary Kemish
Age: 23. Marital status: married. Number of previous pregnancies: 1.
Most recent employment: factory worker.
Partner's employment: army private.
Housing: rented house in suburban area.
Weight History
Jackie noted that she first put on weight when she gave up smoking when she was 15 but after dieting managed to resume her original weight. She kept her weight down until her first pregnancy when she gained a lot of weight which she was unable to lose. She was dissatisfied with her weight and size and felt that it was attibutable to her previous pregnancy rather than her food intake which she felt was quite low.
Weight before pregnancy: 87kg.
Weight at 30 weeks pregnant: 99kg.
Weight six weeks after childbirth: 80kg.

18. Louise Marsden
Age: 28. Marital status: married. Number of previous pregnancies: 0.
Most recent employment: assistant at horse stables.
Partner's employment: clerical officer.
Housing: own house in suburban area.
Weight History
Louise felt that she had always been fat. She went on her first diet when she was 16 and had dieted on and off almost constantly following this. She found that weight loss only occurred initially and could not be sustained over the long term. Her food consumption was very small and she attributed her size to genetic factors. She was dissatisfied with her weight.
Weight before pregnancy: 87kg.
Weight at 30 weeks pregnant: 94kg.
Weight six weeks after childbirth: 90kg.

19. Margaret Marshall
Age: 34. Marital status: married. Number of previous pregnancies: 0.
Most recent employment: clerical worker.
Partner's employment: sales engineer.
Housing: own house in a suburban area.
Weight History
Margaret noted that she started putting on weight after her marriage and attributed this to eating differently and being on 'the pill'. She had been dieting on and off for the last few years. She lost some weight immediately before she got pregnant. She was marginally dissatisfied

with her weight before the pregnancy.
Weight before pregnancy: 83kg.
Weight at 30 weeks pregnant: 90kg.
Weight six weeks after childbirth: 87kg.

20. Joanne McCormack
Age: 24. Marital status: married. Number of previous pregnancies: 0
Most recent employment: bank cashier.
Partner's employment: bank cashier.
Housing: own house in an urban area.
Weight History
Joanne felt that she had always been big but had never been particularly bothered about this. She had never dieted.
Weight before pregnancy: 80kg.
Weight at 30 weeks pregnant: 91kg.
Weight six weeks after childbirth: 90kg.

21. Alison Norris
Age: 27. Marital status: married. Number of previous pregnancies: 0.
Most recent employment: retail manager.
Partner's employment: sales manager.
Housing: own house in an urban area.
Weight History
Alison felt that she had always had a weight problem although she was not really conscious of it until she left school. She first started dieting when she was 18 and had dieted almost constantly since then. She felt that her size was partly attributable to hereditary factors but that her eating habits contributed to this too. She was dissatisfied with her weight and size.
Weight before pregnancy: 90kg.
Weight at 30 weeks pregnant: 99kg.
Weight six weeks after childbirth: 104kg.

22. Judith Osborne
Age: 27. Marital status: married. Number of previous pregnancies: 0.
Most recent employment: factory worker.
Partner's employment: factory worker.
Housing: own house in suburban area.
Weight History
Judith recalled being conscious of her weight since her teens. She went on her first diet when she was 18 which was successful only in the short term. At this time her weight fluctuated according to whether she was dieting or not until she met her husband when she gained a lot of weight. After her marriage she stopped dieting and she had felt fairly satisfied with her weight and size since then. She did not attribute her size to any particular factors.
Weight before pregnancy: 103kg.
Weight at 30 weeks pregnant: 110kg.
Weight six weeks after childbirth: 100kg.

23. Helen Palmer
Age: 32. Marital status: Married.

Number of previous pregnancies: 3 (one ended in miscarriage and one in a stillbirth).
Most recent employment: catering manager.
Partner's employment: self-employed business consultant.
Housing: own house in a suburban area.
Weight History
Helen recalled that she had always been overweight and had been dieting on and off since her teens. She felt that contributory factors to her size were her job in catering which allowed her easy access to food, her metabolism which she viewed as being 'slow' and having four pregnancies very close together. She was dissastisfied with her weight.
Weight before pregnancy: 93kg.
Weight at 30 weeks pregnant: 98kg.
Weight six weeks after childbirth: 93kg.

24. Michelle Pointer
Age: 21. Marital status: cohabiting. Number of previous pregnancies: 0.
Most recent employment: clerical worker.
Partner's employment: factory worker.
Housing: living with her boyfriend in her parents' house in an urban area.
Weight History
Michelle noted that she was first conscious of being fat when she worked in catering and that this occurred because of the accessibility of food that accompanies this type of work. She tried dieting at this time but was unsuccesful. When she left this work she did manage to lose some weight and felt fairly satisfied with her weight before she got pregnant. She attributed her size to hereditary factors.
Weight before pregnancy: 90kg.
Weight at 30 weeks pregnant: 97kg.
Weight six weeks after childbirth: 93kg.

25. Katie Price
Age: 27. Marital status: married. Number of previous pregnancies: 1.
Most recent employment: beautician.
Partner's employment: leisure centre manager.
Housing: own house in suburban area.
Weight History
Katie recalled that she had always been fat and had been unhappy about her size for most of her life. She went on her first diet when she was about 14 and had dieted almost constantly in the following years until she met her husband. Following her marriage she felt less unhappy and self-conscious about her weight and stopped dieting. She felt that her size was largely attributable to genetic factors although noted that her diet was also important in this.
Weight before pregnancy: 87kg.
Weight at 30 weeks pregnant: 90kg.
Weight six weeks after childbirth: 80kg.

26. Liz Roberts
Age: 28. Marital status: married. Number of previous pregnancies: 2.
Most recent employment: shop assistant. Partner's employment: labourer.
Housing: council house in a suburban area.

Weight History
Liz recalled being fat as a child but losing weight and becoming slimmer during her teens. She put on a lot of weight during her first pregnancy and again with the second. Both times this weight was hard to lose This weight gain she attributed to eating the wrong things. She felt dissatisfied about her weight.
Weight before pregnancy: 83kg.
Weight at 30 weeks pregnant: 91kg.
Weight six weeks after childbirth: 90kg.

27. Josie Robbins
Age: 20. Marital status: single. Number of previous pregnancies: 0.
Most recent employment: clerical officer.
Housing: living with her parents in their own house in a suburban area.
Weight History
Josie felt that she had always been fat and first dieted when she was 15. This diet was successful only in the short term and she made no determined dieting attempts after this. She was dissatisfied with her weight. She felt very unhappy about being fat while pregnant because she felt that this might be harmful for the baby. She attributed her size to her diet.
Weight before pregnancy: 98kg.
Weight at 30 weeks pregnant: 101kg.
Weight six weeks after childbirth: 95kg.

28. Gill Russell
Age: 25. Marital status: married. Number of previous pregnancies: 1.
Most recent employment: bank cashier.
Partner's employment: computer systems engineer.
Housing: own house in a suburban area.
Weight History
Gill recalled being conscious of her size from her teens and noted that she started dieting at this time. She had dieted almost constantly since then. She felt that her size was partly genetic but that it was also connected to the types and amount of food that she ate. She was dissatisfied with her weight.
Weight before pregnancy: 90kg.
Weight at 30 weeks pregnant: 97kg.
Weight six weeks after childbirth: 90kg.

29. Carol Smith
Age: 26. Marital status: married.
Number of previous pregnancies: 1 (miscarried).
Most recent employment: building society cashier.
Partner's employment: police officer.
Housing: own house in a suburban area.
Weight History
Carol noted that she became fat after her marriage and that this was because her diet changed and also because eating became more of a social activity that they enjoyed sharing. Both of these led to an increase in food intake. She had tried several diets in recent years but none was successful in the long term. She was dissatisfied with her weight.
Weight before pregnancy: 96kg.
Weight at 30 weeks pregnant: 107kg.

Weight six weeks after childbirth: 96kg.

30. Amanda Spelling
Age: 23. Marital status: married. Number of previous pregnancies: 1.
Most recent employment: nursery nurse.
Partner's employment: computer systems programmer.
Housing: own house in a suburban area.
Weight History
Amanda noted that she had always been aware of being fat. She first dieted when she was about 15 and had dieted on and off ever since. She gained a lot of weight after her marriage and during her first pregnancy and she was unable to lose all of this. She felt that her size was a direct result of overeating. She was dissatisfied with her weight but less so than she had been before her marriage.
Weight before pregnancy: 96kg.
Weight at 30 weeks pregnant: 109kg.
Weight six weeks after childbirth: 106kg..

31. Mary Thompson
Age: 24. Marital status: cohabiting.
Number of previous pregnancies: 6 (four miscarried and one ectopic pregnancy).
Most recent employment: never been in paid employment.
Partner's employment: driver.
Housing: council flat in an urban area.
Weight History
Mary noted that she had always been fat and had been very dissatisfied with her weight and size until just before the current pregnancy. She dieted for a number of years, mostly unsuccessfully, but joined WeightWatchers shortly before she became pregnant and managed to lose quite a bit of weight. She felt that the reason for her size was because she was eating all the 'wrong' sorts of foods and that she tended to eat for comfort when she was upset. Weight before pregnancy: 103kg.
Weight at 30 weeks pregnant: 99kg.
Weight six weeks after childbirth: 92kg.

32. Fiona Tindall
Age: 26. Marital status: married.
Number of previous pregnancies: 2 (one miscarried).
Most recent employment: nurse. Partner's employment: lorry driver.
Housing: council flat in an urban area.
Weight History
Fiona noted that she had always been fat and had always been unhappy about it. She first dieted when she was 12 and since then has dieted on and off almost constantly. She found that her diets were successful only initially. She felt that the cause of her size was her food intake and also because of her metabolism. She was very dissatisfied with her weight and size.
Weight before pregnancy 103kg.
Weight at 30 weeks pregnant: 110kg.
Weight six weeks after childbirth: 96kg.

33. Anne Walker
Age: 20. Marital status: single. Number of previous pregnancies: 0.
Most recent employment: child care assistant.
Housing: living with her parents in their own house in a suburban area.
Weight History
Anne noted that she only became conscious of being fat during this pregnancy and was quite satisfied with her weight prior to this. She attributed this weight gain to the pregnancy. She had never been on a diet.
Weight before pregnancy: 70kg.
Weight at 30 weeks pregnant: 92kg.
Weight six weeks after childbirth: 73kg.

34. Sarah Wells
Age: 29. Marital status: married.
Number of previous pregnancies: 4 (one miscarried).
Most recent employment: secretary. Partner's employment: army private.
Housing: rented house in suburban area.
Weight History
Sarah noted that she was satisfied with her weight and size until her second pregnancy when she put on a lot of weight which she was unable to lose. She tried to diet but found this impossible and so gave up as she felt fairly resigned to being fat and only marginally dissatisfied with her size. She felt that her size was partly genetic although she was aware that she had a tendency to eat a lot of snacks and sweets and felt that this was also a contributory factor.
Weight before pregnancy: 90kg.
Weight at 30 weeks pregnant: 96kg.
Weight six weeks after childbirth: 97kg.

35. Claire Whitcher
Age: 29. Marital status: married.
Number of previous pregnancies: 3 (all miscarried).
Most recent employment: factory worker.
Partner's employment: factory transport supervisor.
Housing: council flat in a suburban area.
Weight History
Claire noted that she had always been fat and had always felt dissatisfied with her weight. She went on her first diet in her late teens. She joined WeightWatchers two years ago and had managed to lose a large amount of weight before becoming pregnant. As a result she was satisfied with her weight and size immediately before this pregnancy. She felt that the reason for her size before her weight loss was her eating habits.
Weight before pregnancy: 70kg.
Weight at 30 weeks pregnant: 103kg.
Weight six weeks after childbirth: 101kg.

36. Julie Woodford
Age: 25. Marital status: married. Number of previous pregnancies: 0.
Most recent employment: shop assistant.
Partner's employment: factory worker.
Housing: own home in a suburban area.

Weight History
Julie noted that she first became fat when she was 17 and attributed going on 'the pill' as the main cause of her size. She was not particularly unhappy about her size at that time but gradually became more dissatisfied with it. She went on a WeightWatchers diet when she was 23 but found it unsuccessful. Since then she had tried to watch her food consumption but felt only marginally dissatisfied with her weight.
Weight before pregnancy: 83kg.
Weight at 30 weeks: 92kg.
Weight six weeks after childbirth: 97kg.

37. Rebecca Young
Age: 19. Marital status: single. Number of previous pregnancies: 0.
Most recent employment: shop assistant.
Housing: living with her parents in their council house in an urban area.
Weight History
Rebecca recalled being conscious of being 'big' and feeling dissatisfied about her weight from the age of about 14. She had wanted to lose some weight since then but had never dieted. She attributed her size to her food consumption.
Weight before pregnancy: 70kg.
Weight at 30 weeks pregnant: 95kg.
Weight six weeks after childbirth: 77kg.

APPENDIX 6

Letter For Consultant/ Midwives/ G.P.'s

Department of Sociology and Social Policy,
University of Southampton,
Southampton.
SO9 5NH

Dear

I am a post-graduate research student in the sociology department of Southampton University under the supervision of Dr. Agnes Miles and I am carrying out some research on the social aspects of obesity in pregnancy for my PhD. The aims of my research are: to identify the contribution of social causes to obesity in pregnancy; to examine the experience of being obese in pregnancy; and to examine the effect the social aspects of pregnancy, childbirth and motherhood have on weight and eating after pregnancy. To carry out this study I have had the co-operation of local hospitals and have identified women to be interviewed from maternity records held at the hospitals. I am interviewing about 40 women for the study. The women interviewed are those who attain the weight of at least 90kg by the 30th week of pregnancy and the women are interviewed twice: during late pregnancy and about six weeks after childbirth.

An important part of my research focuses on the sorts of advice obese pregnant women receive about weight and eating from the various medical professionals that they come into contact with during pregnancy, and whether such advice is complied with. This has been discussed with the women I have interviewed but I feel it is necessary to supplement this with some views from medical professionals involved in maternity care. With this end in mind, I wonder if it would be possible for me to come and talk to you. I would be interested to know your personal views regarding what weight you consider constitutes obesity in pregnancy, what health risks you view as associated with this condition and the sorts of comments or advice (if any) you would be likely to give to obese pregnant women under your care.

I appreciate that you are very busy but I would be grateful if you, or one of your colleagues, could spare the time to talk to me. I would anticipate that I would take up no more than 20 minutes of your time.

I look forward to hearing from you. If you can spare the time to see me I will phone to arrange a mutually convenient time when we can do this.

Yours sincerely,

ROSE WILES

## QUESTIONNAIRE FOR MEDICAL PROFESSIONALS.

Definition Of Obesity In Pregnancy.

1. At a woman's first ante-natal visit, what weight would she have to be for you to consider her:

(i) obese?

(ii) overweight?

2. What do you feel is an excessive weight gain in pregnancy?

3. Roughly what percentage of pregnant women that you see over a year would you consider to be overweight to some degree?

Health Risks.

4. What, if any, particular health risks do you feel are associated with obesity in pregnancy or during childbirth for either the mother or the baby?

5. Do you feel that smoking or obesity is more of a risk factor during pregnancy?

Advice.

6. Do you routinely give advice about weight or eating to pregnant women (of any size) at ante-natal clinic? If so, what advice do you give?

7. Do you give specific advice to overweight pregnant women at ante-natal clinic? If so, what advice do you give?

8. Do you see it as your role to give advice about these matters or do you consider this to be the role of others?

9. Do you find that obese pregnant women often ask for advice about weight gain or diet? If so, what advice would you give?

10. Do you feel, in general, that advice that is given is followed?

11. Would you give advice regarding an obese woman's weight or diet after childbirth, for example, at the post-natal check-up?

BIBLIOGRAPHY


ABBOTT, P., SAPSFORD, R. 1987. Women And Social Class. London: Tavistock.

ABERCROMBIE, N., HILL, S., TURNER, B. 1988 The Perguin Dictionary Of Sociology. Harmondsworth: Penguin.

ABRAHAM, S., LLEWELLYN-JONES, D. 1984. Eating Disorders: The Facts. Oxford: Oxford University Press.

ABRAMS, B., LAROS, R. 1986. 'Pre-Pregnancy Weight, Weight Gain And Birth Weight'. American Journal Of Obstetrics And Gynaecology. 154:503-509.

ABRAMS, B., PARKER, J. 1988. 'Overweight And Pregnancy Complications'. International Journal Of Obesity. 12:293-303.

ABRAMSON, E., STINSON, S. 1977. 'Boredom And Eating In Obese And Non-Obese Individuals'. Addictive Behaviours. 2:181-185.

ALLAN, G. 1985. Family Life. Oxford: Blackwell.

ALLON, N. 1975. 'The Stigma Of Overweight In Everyday Life'. In G. Bray (ed.) Obesity In Perspective. Washington, U.S.A.: U.S. Government Printing Office.

ALLON, N. 1980. 'Who Is Expert About Fat Discrimination?' Conference paper for The Society For The Study Of Social Problems, Philadelphia, U.S.A.

ANDRES, R. 1980. 'Effect Of Obesity On Total Mortality'. International Journal Of Obesity. 4:381-386.

ARMSTRONG, D. 1983. An Outline Of Sociology As Applied To Medicine. Bristol: Wright.

BALL, J. 1987. Reactions To Motherhood: The Role Of Post-Natal Care. Cambridge: Cambridge University Press.

BEECHEY. V. 1986. 'Women's Employment In Contemporary Britain'. In Beechey, V., Whitelegg, E. Women In Britain Today. Milton Keynes: Open University Press.

BEECHEY, V., WHITELEGG, E. 1986. Women In Britain Today. Milton Keynes: Open University Press.

BENSON, P., SEVERS, D., TATGENHORST, J., LODENGAARD, N. 1980. 'The Social Costs Of Obesity: A Non-Reactive Field Study'. Social Behaviour And Personality. 8:91-96.

BERCHFOLD, P., BERGER, M., JORGENS, V., DAWEKE, C., CHANTELOU, E., GRIES, F., ZIMMERMANN, H. 1981. 'Cardiovascular Risk Factors And HDL-Cholesterol Levels In Obesity'. International Journal Of Obesity. 5:1-10.

BJORNTORP, D., CAIRELLA, M., HOWARD, A. 1981. Recent Advances In Obesity Research: III. Proceedings Of The Third International Congress On Obesity. London: John Libbey.

BLAXTER, M. 1976. The Meaning Of Disability. London: Heinemann.

BLAXTER, M. 1983. 'Social Class, Poverty And Nutrition'. In Turner, M. (ed.) Food And People. London: John Libbey.

BLAXTER, M., PATERSON, E. 1983. 'The Health Behaviour Of Mothers And Daughters'. In Madge, N. (ed.) Families At Risk. London: Heinemann.

BLUNDELL, J., MCARTHUR, R. 1979. Obesity And Its Treatment. Vol. 1. Edinburgh: Churchill Livingstone.

BOULTON, M. 1983. On Being A Mother: A Study Of Women With Pre-School Children. London: Tavistock.

BOVEY, S. 1989. Being Fat Is Not A Sin. London: Pandora.

BOYD, C., SELLARS, L. 1982. The British Way Of Birth. London: Pan.

BRADFORD, N. 1988. 'Beat The Baby Bulge'. WeightWatchers Magazine. August/September:32-34.
BRADLEY, P. 1985. 'Conditions Recalled To Have Been Associated With Weight Gain In Adulthood'. Appetite. 6:235-241.
BRANNEN, J. 1988. 'Research Note: The Study Of Sensitive Subjects'. Sociological Review. 36:552-563.
BREAKWELL, G. 1986. Coping With Threatened Identities. London: Methuen.
BREEN, D. 1981. Talking With Mothers. London: Jill Norman.
BRITISH MEDICAL JOURNAL. 1974. 'Men, Women And Obesity'. British Medical Journal. 4:249-250.
BROWN, A. 1977. Conference paper for The Society For The Study Of Social Problems, U.S.A. 'Moving Towards An Acceptance Of Fatness: Problems Of Discrimination'.
BROWN, G., HARRIS, T. 1978. The Social Origins Of Depression. London: Tavistock.
BRUCH, H. 1974. Eating Disorders: Obesity, Anorexia Nervosa And The Person Within. London: Routledge and Kegan Paul.
BRUNZELL, J. 1984. 'Are All Obese Patients At Risk For Cardiovascular Disease'. International Journal Of Obesity. 8:571-578.
BRYAN, B., DADZIE, S. SCAFE, S. 1985. The Heart Of The Race: Black Women's Lives In Britain. London: Virago.
BULMER, M. (ed.) 1977. Sociological Research Methods: An Introduction. London: Macmillan.
BULMER, M. 1982. Social Research Ethics. London: Macmillan.
BURGESS, R. 1984. In The Field: An Introduction To Field research. London: George Allen And Unwin.
BURTON, B., FOSTER, W., HIRSCH, J., ITALLIE, T. 1985. 'Health Implications Of Obesity: An NIH Consensus Development Conference'. International Journal Of Obesity. 9:155-169.
BUSFIELD, J. 1988. 'Mental Illness As A Social Product Or Social Construct: A Contradiction In Feminists' Arguments'. Sociology Of Health And Illness. 10:521-542.
CALNAN, M. 1990. 'Food And Health: A Comparison Of Beliefs And Practices In Middle-Class And Working-Class Households'. In Cunningham-Burley, S., McKeganey, N. Readings In Medical Sociology. London: Routledge.
CAMPBELL, D., GILLMER, M. 1982. Nutrition In Pregnancy. Proceedings Of The 10th Study Group Of The Royal College Of Obstetricians And Gynaecologists. London: Royal College Of Obstetricians And Gynaecologists.
CANDIB LARKIN, J., PINES, H. 1979. 'No Fat Persons Need Apply'. Sociology Of Health And Occupation. 6:312-317.
CANNON, G. 1987. The Politics Of Food. London: Century Hutchinson.
CATALDO, J. 1985. 'Obesity: A New Perspective On An Old Problem'. Health Education Journal. 44:213-216.
CHARLES, N., KERR, M. 1986a. 'Food For Feminist Thought'. Sociological Review. 34:537-572.
CHARLES, N., KERR, M. 1986b. 'Eating Properly, The Family And The State'. Sociology. 20:412-429.
CHARLES, N., KERR, M. 1988. Women, Food And Families. Manchester: Manchester University Press.
CHERNIN, K. 1983. The Tyranny Of Slenderness. London: The Women's Press.
CLINE, S. LEAN, C. 1987. 'Just Desserts: Women And Food'. Transcript from the 'Ideas' programme, Canadian Broadcasting Company.

CLINE, S., SPENDER, D. 1987. Reflecting Men At Twice Their Natural Size. London: Andre Deutsch.
COLE-HAMILTON, I., LANG, T. 1986. Tightening Belts. London: London Food Commission.
CONRAD, P. 1981. 'On The Medicalisation Of Deviance And Social Control'. In Ingleby, D. (ed.) Critical Psychiatry. Harmondsworth: Penguin.
CORNWELL, J. 1984. Hard-Earned Lives. London: Tavistock.
COWARD, R. 1984. Female Desire. London: Paladin.
COWARD, R. 1988. 'Fergie's Flab'. New Statesman And Society. 19.8.88:20.
COX, D., ET AL. 1987. The Health And Lifestyles Survey. London: Health Promotion Research Trust.
CRADDOCK, D. 1969. Obesity And Its Management. London: Livingstone.
CRADDOCK, D. 1989. 'Discussion'. International Journal Of Obesity. 13:149.
CUNNISON, S. 1989. 'Gender Joking In The Staffroom'. In Acker, S. (ed.) Teachers, Gender And Careers. Sussex: Falmer.
DEEM, R. 1986. All Work And No Play? A Study Of Women And Leisure. Milton Keynes: Open University Press.
DEJONG, W. 1980. 'The Stigma Of Obesity: The Consequences Of Naive Assumptions Concerning The Causes Of Physical Deviance'. Journal Of Health And Social Behavour. 21:75-87.
DELPHY, C. 1984. Close To Home: A Materialist Analysis Of Women's Oppression. London: Hutchinson.
D.H.S.S. 1976. Prevention And Health: Everybody's Business: A reassesment Of Public And Personal Health. London: H.M.S.O.
DINGWALL, R. 1980. 'Ethics And Ethnography'. Sociological Review. 28:871-891.
DOYLE, W., CRAWFORD, M., LAURANCE, B., DRURY, P. 1982. 'Dietary Survey During Pregnancy In A Low Socio-Economic Group'. Human Nutrition: Applied Nutrition. 36A:95-106.
DREWNOWSKI, A. 1985. 'Food Perceptions And Preferences Of Obese Adults: A Multidimensional Approach.' International Journal Of Obesity. 9:201-212.
DRIFE, J. 1986. 'Weight Gain In Pregnancy: Eating For Two Or Just Getting Fat?' British Medical Journal. 293:903-904.
EICHLER, M. 1988. Nonsexist Research Methods. Mass., U.S.A.: Allen and Unwin.
EISENSTEIN, H. 1984. Contemporary Feminist Thought. London: Unwin.
FAGIN, L., LITTLE, M. 1984. The Forsaken Families. Harmondsworth: Penguin.
FARADAY, A., PLUMMER, K. 1979. 'Doing Life Histories.' Sociological Review. 27:773-796.
FINCH, J. 1984. ''It's Great To Have Someone To Talk To': The Ethics And Politics Of Interviewing Women.' in Bell, C., Roberts, H. Social Researching: Politics, Problems, Practice. London: Routledge and Kegan Paul.
FOREYT, J. 1977. Behavioural Treatments Of Obesity. Oxford: Pergamon Press.
FRIEDAN, B. 1965. The Feminine Mystique. Harmondsworth: Penguin.
GARBACIAK, J., RICHTER, M., MILLER, S., BARTON, J. 1985. 'Maternal Weight And Pregnancy Complications'. American Journal Of Obstetrics And Gynaecology. 152:238-245.
GARROW, J. 1981. Treat Obesity Seriously: A Clinical Manual. Edinburgh: Churchill Livingstone.

GARROW, J., WEBSTER, J. 1985. 'Quetelet's Index (W/H2) As A Measure Of Fatness'. International Journal Of Obesity. 9:147-153.
GILBERT, S. 1989. Tomorrow I'll Be Slim: The Psychology Of Dieting. London: Routledge.
GILLMER, M. 1982. 'Obesity In Pregnancy - Clinical And Metabolic Effects' in Campbell, D., Gillmer, M. Nutrition In pregnancy. Findings Of The Tenth Study Group Of The Royal College Of Obstetricians And Gynaecologists. London: Royal College of Obstetricians and Gynaecologists.
GOFFMAN, E. 1971. The Presentation Of Self In Everyday Life. Harmondsworth: Pelican.
GORDON, T. 1990. Feminist Mothers. Basingstoke: Macmillan.
GRAHAM, H. 1976. 'The Social Image Of Pregnancy: Pregnancy As Spirit Possession' Sociological Review. 74:291-305.
GRAHAM, H. 1977. 'Women's Attitudes To Conception And Pregnancy'. In Chester, R. and Peel, J. Equalities And Inequalities In Family Life. London: Academic Press.
GRAHAM, H. 1983. 'Do Her Answers Fit His Questions? Women And The Survey Method'. In Garmarnikow, E., Morgan, D., Purvis, J., Taylorson, D. (eds.) The Public And The Private. London: Heinnemann
GRAHAM, H. 1984a. Women, Health And The Family. Brighton: Wheatsheaf.
GRAHAM, H. 1984b. 'Surveying Through Stories'. In Bell, C., Roberts, H. Social Researching: Politics, Problems, Practice. London: Routledge and Kegan Paul.
GRAHAM, H. 1986. Caring For The Family: A Short Report Of The Organisation Of Health Resources And Responsibilities In 102 Families With Pre-School Children. Research Report No. 1. London: Health Education Council.
GREAVES, M. 1990. Big And Beautiful: Challenging The Myths And Celebrating Our Size. London: Grafton.
GREENE, G., SMICIKLAS-WRIGHT, H., SCHOLL, T., KARP, R. 1988. 'Postpartum Weight Change: How Much Of The Weight Gained In Pregnancy Will Be Lost After Delivery'. Obstetrics And Gynaecology. 71:701-707
GREENHILL, J., FRIEDMAN, E. 1974. Biological Principles And Modern Practice Of Obstetrics. Philadelphia, U.S.A.: W.B. Saunders.
GREER, G. 1971. The Female Eunuch. London: Granada.
GROSS, T., SOKOL, R.J., KING, K. 1980. 'Obesity In Pregnancy: Risks And Outcome'. Obstetrics And Gynaecology. 56:446-450.
HANES, F. 1986. 'Food And The Fowler Reviews.' (Unpublished report).
HARRIS, M. 1983. 'Eating Habits, Restraint, Knowledge And Attitudes Towards Obesity'. International Journal Of Obesity. 7:271-286.
HARRIS, M., HARRIS, R., BOCHNER, S. 1982. 'Fat, Four-Eyed, And Female: Stereotypes Of Obesity, Glasses And Gender'. Journal Of Applied Social Psychology. 12:503-516.
HARRIS, M., SMITH, S. 1983. 'The Relationship Of Age, Sex, Ethnicity, And Weight To Stereotypes Of Obesity And Self Perception'. International Journal Of Obesity. 7:361-371.
HARRISON, G., UDALL, J., MORROW, G. 1980. 'Maternal Obesity, Weight Gain In Pregnancy, and Infant Birth Weight'. American Journal Of Obstetrics And Gynaecology. 136:411-412.
HAUG, F. 1987. Female Sexualisation: A Collective Work Of Memory. London: Verso.

HAWORTH, J., ELLESTAD,-SAYED, J., KING, J., DILLING, C. 1980. 'Relation Of Maternal Cigarette Smoking, Obesity And Energy Consumption To Infant Size'. American Journal Of Obstetrics And Gynaecology. 138:1185-1189.
HEALTH EDUCATION AUTHORITY. 1984. Pregnancy Book. London: Health Education Authority.
HILLIER, D. 1981. 'The Salience Of Overweight In Personality Characterisation'. Journal of Psychology. 108:233-240.
HODGKINSON, R., HUSAIN, F. 1981. 'Caesarean Section Associated With Gross Obesity'. Obstetrical And Gynaecological Survey. 36:241-242.
HOMANS, H. 1983. 'A Question Of Balance: Asian And British Women's Perceptions Of Food During Pregnancy'. In Murcott, A. (ed.) The Sociology Of Food And Eating. Aldershot: Gower.
HOOK, E. 1980. 'Influence Of Pregnancy On Dietary Selection'. International Journal Of Obesity. 4:338-340.
HUGHES, J. 1976. Sociological Analysis: Methods Of Discovery. Middlesex: Thomas Nelson.
HYTTEN, F., LEITCH, I. 1971. The Physiology Of Human Pregnancy. Oxford: Blackwell Scientific Publications.
IFFY, L., KAMINETZKY, A. 1981. Principles And Practice Of Obstetrics And Perinatology. New York, U.S.A.: John Wiley.
JAMES, W. 1976. Research On Obesity: A Report Of The DHSS/MRC Group. London: HMSO.
JENKINS, T., SMITH, H. 1987. 'Fat Liberation'. Spare Rib. 182:14-18.
KALLEN, D., DOUGHTY, A. 1984. 'The Relationship Of Weight, The Self-Perception Of Weight And Self-esteem With Courtship Behaviour'. Marriage And Family Review. 7:93-114.
KARPF, A. 1988. Doctoring The Media: The Reporting Of Health And Medicine. London: Routledge.
KERR, M., CHARLES, N. 1986. 'Servers And Providers: The Distribution Of Food Within The Family'. Sociological Review. 34:115-157.
KLIEGMAN R., GROSS, T. 1985. 'Perinatal Problems Of The Obese Mother And Her Infant'. Obstetrics And Gynaecology. 66:299-305.
LANG, T., ANDREWS, H., BEDALE, C., HANNAN, E. 1984. Jam Tomorrow? A Report Of The Food Circumstances, Attitudes And Consumption Of 1000 People On Low Incomes In The North Of England. Manchester: Food Policy Unit, Manchester Polytechnic.
LAWRENCE, M. (ed.). 1987. Fed Up And Hungry: Women, Oppression And Food. London: The Women's Press.
LIPINSKI, B. 1975. 'Life Change Events As Correlates Of Weight Gain'. In Howard, A. (ed.) Recent Advances In Obesity Research: 1. London: John Libbey.
LIPPINCOTT, J. 1965. Aspects Of Anxiety. Philadelphia, U.S.A.: J.B. Lippincott.
LOWE, M., FISHER, E. 1983. 'Emotional Reactivity, Emotional Eating And Obesity: A Naturalistic Study'. Journal Of Behavioural Medicine. 6:135-149.
MACINTYRE, S. 1977. Single And Pregnant. London: Croom Helm.
MACINTYRE, S. 1981. Expectations And Experiences Of First Pregnancy: Report On A Prospective Interview Study Of Married Primigravidae In Aberdeen. Aberdeen: Occassional Paper No. 5, Institute Of Medical Sociology.
MANN, M. 1983. The Macmillan Student Encyclopedia Of Sociology. London: Macmillan.

MANSFIELD, P., COLLARD, J. 1988 The Beginning Of The Rest Of Your Life? Basingstoke: Macmillan.
MARSHALL, G., ROSE, D., NEWBY, H., VOGLER, C. 1989. Social Class In Modern Britain. London: Unwin Hyman.
MARTIN, E. 1989. The Woman In The Body. Milton Keynes: Open University Press.
MCBRIDE, A. 1982. 'Obesity Of Women During The Childbearing Years. Psychosocial And Physiologic Aspects'. Nursing Clinics Of North America. 17:217-224.
MEASOR, L. 1983. 'Gender And The Sciences: Pupil's Gender-Based Conceptions Of School Subjects'. In Hammersley, M., Hargreaves, A. (ed.) Curriculum Practice: Some Sociological Case Studies. Sussex: Falmer.
MELVILLE, J. 1983. The ABC Of Eating. London: Sheldon Press.
MILES, A. 1987. The Mentally Ill In Contemporary Society. Oxford: Blackwell.
MILES, A. 1988. Women And Mental Illness: The Social Context Of Female Neurosis. Brighton: Wheatsheaf.
MINNS, R. 1980. Bombers And Mash: The Domestic Front 1939-45. London: Virago.
MITCHELL, J., OAKLEY, A. 1986. What Is Feminism? Oxford: Blackwell.
MUNRO, J. 1979. The Treatment Of Obesity. Lancaster: MTP Press.
MURCOTT, A. 1982a 'One Man's Meat'. Nutrition And Food Science. 76:2-4.
MURCOTT, A. 1982b 'Menus, Meals And Platefuls: Observations On Advice About Diet In Pregnancy'. International Journal Of Sociology And Social Policy. 2:1-11.
MURCOTT, A. (ed.) 1983. The Sociology Of Food And Eating. Aldershot: Gower.
MURCOTT, A. 1987. 'Conceptions Of Food: A Sociological Analysis'. Phd. Thesis, University Of Wales.
MURCOTT, A. 1988. 'On The Altered Appetites Of Pregnancy: Conceptions Of Food, Body And Person'. Sociological Review. 36:733-764.
NATHANSON, C. 1975. 'Illness And The Feminine Role: A Theoretical Review'. Social Science And Medicine. 9:57-62
OAKLEY, A. 1980. Women Confined. Oxford: Martin Robertson.
OAKLEY, A. 1981. Subject Women. London: Fontana.
OAKLEY, A. 1986a. From Here To Maternity. Harmondsworth: Pelican.
OAKLEY, A. 1986b. Telling The Truth About Jerusalem. Oxford: Blackwell.
OLSEN, J., FRISCHE, G. 1987. 'Comparison Of A Dietary Attitude Index Based On Questionnaire Data And A Seven Day Diet Recall Interview: A Study Among Pregnant Women'. Social Science And Medicine. 24:379-382.
ORBACH, S. 1978. Fat Is A Feminist Issue. Feltham: Hamlyn.
ORBACH, S. 1984. Fat Is A Feminist Issue 2. Feltham: Hamlyn.
ORFORD, J. 1985. Excessive Appetites: A Psychological View Of Addictions. Chichester: John Wiley.
ORR, J. 1936. Food, Health And Income: Report On A Survey Of Adequacy Of Diet In Relation To Income. London: Macmillan.
PARHAM, E., KING, S., BEDELL, M., MARTERSTECK, S. 1986. 'Weight Control Content Of Women's Magazines: Bias And Accuracy'. International Journal Of Obesity. 10:19-27.
PLUMMER, K. 1983. Documents Of Life: An Introduction To The Problems And Literature Of A Humanistic Method. London: George Allen And Unwin.
POWER, C., MOYNIHAN, C. 1988. 'Social Class And Changes In Weight-For-Height Between Childhood And Early Adulthood'. International Journal Of Obesity. 12:445-453.

PRICE, J. 1988. Motherhood: What It Does To Your Mind. London: Pandora.
PUNCH, M. 1986. The Politics And Ethics Of Fieldwork. Beverly Hills: Sage.
RAU, J., GREEN, R. 1975. 'Compulsive Eating: A Neuropsychologic Approach To Certain Eating Disorders'. Comprehensive Psychiatry. 16:223-231.
ROBERTS, H. (ed.). 1981. Doing Feminist Research. London: Routledge and Kegan Paul.
RODIN, J. 1980. 'Social And Immediate Environmental Influences On Food Selection'. International Journal Of Obesity. 4:364-370.
ROOKUS, M., ROKEBRAND, P., BUREMA, J., DEURENBERG, P. 1987. 'The Effect Of Pregnancy On The Body Mass Index Nine Months Postpartum In 49 Women'. International Journal Of Obesity. 11:609-618.
ROOKUS, M., BUREMA, J., FRIJTERS, J. 1988. 'Changes In Body Mass Index In Young Adults In Relation To Number Of Life Events Experienced'. International Journal Of Obesity. 12:29-39.
ROSENBLUM, K. 1975. 'Female Deviance And The Female Sex Role: A Preliminary Investigation'. British Journal Of Sociology. 26:169-184.
ROTH, G. 1982. Feeding The Hungry Heart. New York: Bobbs-Merrill.
ROYAL COLLEGE OF MIDWIVES. 1987. Your First Baby. London: The Newbourne Group.
ROYAL COLLEGE OF PHYSICIANS. 1983. 'Obesity. A Report Of The Royal College Of Physicians'. Reprinted from The Journal Of The Royal College Of Physicians. 17:5-65.
RUGE, S., ANDERSEN, T. 1985. 'Obstetric Risks In Obesity: An Analysis Of The Literature'. Obstetrical And Gynaelogical Survey. 40:57-60.
SANDLER, M. 1978. Mental Illnes In Pregnancy And The Puerperium. Oxford: Oxford University Press.
SAUNDERS, P. 1990. Social Class And Stratification. London: Routledge.
SCHOENFIELDER, L., WIESER, B. 1983. Shadow On A Tightrope: Writings By Women On Fat Oppression. Iowa: Aunt Lute Book Comapany.
SCHREINER, O. 1978. Woman And Labour. London: Virago.
SCOTT, H. 1984. Working Your Way To The Bottom: The Feminization Of Poverty. London: Pandora.
SHARPE, S. 1976. Just Like A Girl. Harmondsworth: Penguin.
SHEPHERD, R. 1988. 'Sweet Revenge'. WeightWatchers Magazine. August/September:45-47.
SHILLING, C. 1991. 'Educating The Body: Physical Capital And The Production Of Social Inequalities'. Sociology. (forthcoming).
SICHTERMANN, B. 1986. Femininity: The Politics Of The Personal. Cambridge; Polity Press.
SILVERSTONE, T. 1975. Obesity: Its Pathogenesis And Management. Lancaster: Medical And Technical Publishing Company.
SLOCHOWER, J. 1983. Excessive Eating: The Role Of Emotions And The Environment. New York: Human Sciences Press.
SMITH, D. 1988. The Everyday World As Problematic: A Feminist Sociology. Milton Keynes: Open University Press.
SPENDER, D. 1980. Man Made Language. London: Routledge and Kegan Paul.
STACEY, M. 1981. 'The Division Of Labour Revisited, Or Overcoming The Two Adams'. In Abrams, P. et al (eds). Practice And Progress: British Sociology 1950-1980. London: Allen and Unwin.
STANLEY, L., WISE, S. 1983. Breaking Out: Feminist Consciousness And Feminist Research. London: Routledge and Kegan Paul.

STEWART, J., WHEELER, E., SCHOFIELD, C. 1988. 'Regional Differences In British Attitudes To Diet In Pregnancy: Priorities And Pragmatism'. Ecology Of Food And Nutrition. 20:211-229.
STOCK, M., ROTHWELL, N. 1982. Obesity And Leanness: Basic Aspects. London: John Libbey.
STUDD, J. 1984. Progress In Obstetrics And Gynaecology. London: Churchill Livingstone.
TAKING LIBERTIES COLLECTIVE. 1989. Learning The Hard Way: Women's Oppression In Men's Education. Basingstoke: Macmillan.
TEDDERN, S. 'Fat Pride And Prejudice'. The Guardian. 14.2.89:21.
TREHARNE, I. 1983. 'A Study Of Obesity In Pregnancy And Its Association With Fetal Macrosomia'. M.D. Thesis, University Of Aberdeen.
TURNER, B. 1982. 'The Government Of The Body: Medical Regimens And The Rationalization Of Diet'. British Journal Of Sociology. 33:254-269.
TURNER, B. 1984. The Body And Society. Oxford: Basil Blackwell.
TURNER, B. 1987. Medical Power And Social Knowledge. London: Sage.
TWIGG, J. 1983. 'Vegetarianism And The Meanings Of Meat'. In Murcott, A. (ed.) The Sociology Of Food And Eating. Aldershot: Gower.
VAN STRIEN, T., ROOKUS, M., BERGERS, G., FRIJTERS, J., DEFARES, P. 1986. 'Life Events, Emotional Eating And Change In Body Mass Index'. International Journal Of Obesity. 10:29-35.
WALKER, J., MACGILLIVRAY, I., MACNAUGHTON, M. (eds.). 1976. Combined Textbook Of Obstetrics And Gynaecology. Edinburgh: Churchill Livingstone.
WARR, P. 1987. Work, Unemployment And Mental Health. Oxford: Oxford University Press.
WARREN, S. 1988. Gender Issues In Field Research. Beverly Hills: Sage.
WELBURN, V. 1980. Postnatal Depression. Isle Of Man: Fontana.
WISEMAN, J. 1978. 'The Research Web'. In Bynner, J., Stribley, K. (eds.) Social Research: Principles And Procedures. London,: Longman.
WOLFE, H., GROSS, T., SOKOL, R., BOTTOMS, S., THOMPSON, K. 1988. 'Determinants Of Morbidity In Obese Women Delivered By Caesarean'. Obstetrics And Gynaecology. 71:691-695.
WOOLEY, S., WOOLEY, O. 1979. 'Obesity And Women - 1. A Closer Look At The Facts'. Women's Studies International Quarterly. 2:69-79.
WOOLEY, O., WOOLEY, S., DYRENFORTH, S. 1979. 'Obesity And Women - 11. A Neglected Feminist Topic'. Women's Studies International Quarterly. 2:81-92.
WORSLEY, A. 1981. 'Teenagers' Perceptions Of Fat And Slim People'. International Journal of Obesity. 5:15-24.