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Reproducing stigma: Interpreting "overweight" and "obese" women's experiences of weight-based discrimination in reproductive healthcare

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ABSTRACT

Amidst a barrage of policy documents, bio-medical research, and press items concerned with the "crisis" of obesity, a growing scholarship is concerned with what has come to be known as "obesity stigma." This scholarship hails from a range of sources including critical obesity scholars who problematize the idea of obesity as a health concern, as well as from "mainstream" organizations and researchers who, while maintaining obesity is a world-wide health problem, also argue that "obese" people are the targets of discrimination. In this paper, we analyze both interpretations of obesity stigma, particularly as that stigma applies to obese women's experiences of accessing and receiving reproductive care. We describe a qualitative study conducted with 24 overweight and obese women in 2 Canadian cities. Participants related overt and covert experiences of stigma when accessing reproductive care founded in healthcare practitioners' focus on fetal risk and "mother-blame" which, though partially evidence-based, was interpreted by participants as discriminatory. As such, we maintain that any true interruption of obesity stigma in the reproductive healthcare interaction requires a bridge between critical and mainstream scholarship, and careful attention to the risk-based foci in clinical settings which can be interpreted by clients as moralizing.

1. Introduction

Literature in bio-medicine, public health, and the social sciences has firmly established that stigma is levelled against "obese" people in healthcare (Bombak, 2014a; Puhl et al., 2008; Puhl and King, 2013). A less established literature is beginning to demonstrate "obesity stigma" in reproductive care specifically (Mulherin et al., 2013; Smith and Lavender, 2011). Such stigma is based in evidence that "maternal obesity" (obesity during pregnancy) creates adverse outcomes such as infertility, birth defects, C-section delivery, miscarriage (Catalano, 2007; Moran et al., 2011) and, eventually, childhood obesity (O'Reilly and Reynolds, 2013; Pham et al., 2013). As a result, it has been noted in the literature that larger women are more likely to be judged as "bad (potential) mothers" (McPhail et al., 2016; McNaughton, 2011) according to patriarchal constructions of motherhood and control of women's reproductive capacities and processes (Warin et al., 2012).

Though important work is emerging in maternal obesity stigma, literature in the area remains sparse. This paper attends to these gaps by discussing qualitative research we conducted in 2 sites in Canada with self-identified overweight and obese women. We outline the significant experiences of stigma in reproductive care for our participants and demonstrate how these experiences were founded in rhetoric of risk and mother-blame that circulate within the clinical setting and which participants interpreted as moralizing.

We filter our data through 2 types of literature or problem "frames" (Saguay, 2013) concerned with obesity stigma in the healthcare setting: the "mainstream" approach, propagated by health agencies, groups, and some scholarly literature; and the "critical obesity" approach, as developed by scholars sceptical of obesity as a medical problem (Gard and Wright, 2005; Lupton, 2013). The first, more mainstream, approach suggests that obesity

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should be combatted and that policy, programming, and research must focus on the eradication of "excess" fat from populations, but that individuals with obesity should not be discriminated against for body types beyond their control. In contrast, the second group of critical scholars suggests that obesity stigma is fully and completely embedded in the notion that "excess" fat is unhealthy, and the only way to end fat-based discrimination is to stop presenting fatness as always-already insalubrious.

In our study, participants described a wide variety of stigma, ranging from overt discrimination such as name calling, expressions of disgust, and inadequate medical care to more covert experiences in which participants were made to feel like inadequate (potential) mothers. Such covert instances of stigma were almost always based in by-now-medically-rote understandings of maternal obesity as risky for the fetus and therefore unhealthy. Given that medical professionals may feel reasonably bound to act on such understandings due to the relatively large amount of research underlying them, we end by suggesting clinical approaches to maternal obesity that in Trainer et al.'s (2015) words, "inhabit the tense intersection" between "mainstream" and critical approaches to stigma (p. 66; see also Moffat, 2010). Such a "bridging" recognizes the legitimacy of communicating certain health possibilities to patients while remaining open both to critical literature pointing to the moralism recreated through obesity risk talk and the potential for larger patients to have healthy, incident-free conception, pregnancy and birth experiences.

2. Literature review

2.1. Obesity stigma

Recently, obesity stigma has gleaned much attention in public health, medical, and theoretical literature. Stigma is a concept taken from Goffmanian social theory, and refers to the othering and marginalization of populations deemed different from the norm (Goffman, 1963). Pertaining to obesity, fatness operates as a type of what Goffman named "physical" and "character" stigma that reduces fat people's life chances (for a good job, education, satisfying relationships, and so on) – in other words, fatness "spoils" a person's "identity" – and helps create social inequalities between those with "normal" weights and those perceived as obese.

Size-related stigma is reported in multiple settings, including healthcare (Edelstein et al., 2009; Hayden et al., 2008; Puhl et al., 2008; Puhl and King, 2013; Schwartz et al., 2003; Swift et al., 2013). Studies indicate clinicians believe obese patients to be less motivated, "non-compliant," and to lack "will power" (Hayden et al., 2008; DiGiacinto, 2015). This contributes to negative health outcomes among patients designated "too large," including avoidance of medical care, psychosocial stress, and poor mental health (Phelan et al., 2015; see also Wong et al., 2015).

2.1.1. Problem frames: obesity stigma

Research on the existence of obesity stigma has had influence on various groups dedicated to managing obesity, as such groups now advocate for bias-free clinical spaces. For example, the Canadian Obesity Network (CON), an organization of interested health professionals, researchers, and other "obesity stakeholders" dedicated to obesity "prevention and treatment efforts" is also for the "advancement of anti-discrimination" and "addressing the social stigma associated with obesity" (Canadian Obesity Network, nd(a).; see Fig. 1). Within such a discursive frame, obesity is a chronic disease, and just as a person with "diabetes or high blood pressure" (Canadian Obesity Network, nd(b)) should not be stigmatized, neither should an obese person. Importantly, CON also argues that some individuals may be able to live with the disease of obesity symptom-free, and therefore may not need to lose weight. The same discursive frameworks are evident in the "stigma" discussions on The University of Connecticut Rudd Centre for Food Policy and Obesity's website, wherein documents clearly articulate the low efficacy of weight loss dieting and the pervasiveness of weight bias and its consequences (e.g. Friedman and Puhl, 2012; Puhl, 2013; Puhl, nd.). Similarly, the American Society for Metabolic and Bariatric Surgery notes that "people who suffer from the disease of obesity should be free from prejudice and discrimination in accessing care for obesity" (ASMBS, 2011, p. 261).

Obesity stigma is not only a topic of concern for bio-medical and health sources, but also for scholars typically marginalized from mainstream discourse about obesity: critical fat and obesity scholars (Gard and Wright, 2005; LeBesco, 2004). According to this scholarship, obesity is at least in part a socially constructed category, not a straight-forward biological or epidemiological "truth." Often analyzing obesity through a Foucaultian lens, these scholars argue that ideas about obesity are discursive and, as such, intricately tied to power relations and the legitimation and reproduction of that power through the stigmatization of larger people (Lupton, 2013). For example, because obesity "at-risk groups" as named in public health are already marginalized populations, many scholars have described the ways in which obesity discourse reattaches pathology to racialized groups such as African-American (Herndon, 2005), Indigenous (Fee, 2006), working class (McPhail et al., 2013), and sexual minority people (McPhail and Bombak, 2015). Thus, drawing in part on sociological theory (Lupton, 1999), these scholars point to how "risk" is used institutionally as a technology of surveillance and governance to constitute structurally stigmatized populations in need of regulation. Further, scholars maintain that because fatness has become hyper-racialized, "de-classed," and "queered," the "battle of the bulge" on both individual and population levels is not "simply" a battle against adipose tissue *per se* within mainstream Western societies, but also a battle to maintain the status quo and the power relations that sustain it.

Thus, while both "mainstream" health approaches to obesity and critical obesity scholarship agree that obese people experience stigma, in particular in healthcare settings, critical obesity scholars diverge from mainstream sources by illuminating how obesity stigma is a stand in or re-articulation of other types of oppressions, and can be legitimately practiced in the name of health through obesity rhetoric. A further difference between the two is that the mainstream approach disparages obesity stigma but, as noted, tends to articulate obesity as a disease or inflection of disease. Such approaches to obesity stigma might be celebrated by those invested in healthcare equity for larger people. By characterizing obesity as a disease, such sources challenge the stigmatizing notion that obesity is the fault of individuals with poor health behaviours or who cannot "stick to" a diet (see also Holm, 2007; Kniess, 2015). Articulating obesity as a disease, however, also positions obesity as a condition necessitating prevention and treatment. For example, CON, linking "even modest weight loss" with such "additional health benefits" as "improvement in blood glucose, blood pressure, cholesterol levels, arthritis, reflux disease, sleep apnea, or infertility" (CON, nd., "How much Weight do I have to Lose to be Healthy?"), provides tips for "managing" obesity that seem targeted directly at individuals who should make "healthy and enjoyable lifestyle changes," including weight loss through pharmaceuticals and dieting (given that TOPS, a weight loss group, is listed as a resource; CON, nd. "Resources"). The Rudd Centre's website argues that obesity stigma should be avoided because it "impairs weight loss effort" (Puhl, 2013, slide 40/75)" and may lead to coping by "refusing to diet" (Friedman and Puhl, 2012, p. 3) or "less weight loss" (Puhl, nd, slide 41/79) for individual patients. The American