NARRATIVE ANALYSIS OF BIRTH STORIES BLOGGED BY WOMEN WHO SELF-IDENTIFIED AS OBESE OR PLUS-SIZE

A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

COLLEGE OF NURSING

BY

ROBIN COOK, RN, MSN

DENTON, TEXAS

MAY 2022

ACKNOWLEDGEMENTS

I am extremely grateful to my dissertation Chair, Dr. Mikyoung Angela Lee, PhD, RN for her invaluable advice, supervision, support and tutelage throughout the course of my PhD degree. My gratitude extends to the faculty of Texas Woman's University and I would particularly like to express gratitude to Dr. Fuqin Liu, PhD, RN for inspiring me to take on a qualitative study and for her assistance and encouragement along the way. Thank-you to Dr. Kathy Lauchner, PhD, RN for your wisdom and support. I will always revere you for your leadership and service as a mentor and role model. My appreciation also goes out to my family and friends for their encouragement and support all through my studies.

ABSTRACT

ROBIN COOK, MSN, RN

NARRATIVE ANALYSIS OF BIRTH STORIES BLOGGED BY WOMEN WHO SELF-IDENTIFIED AS OBESE OR PLUS-SIZE

MAY 2022

In the United States, approximately one in three pregnant women are obese. Obesity in pregnancy affects both maternal and fetal health. In addition to physiological risks, there are also risks for psychosocial burdens placed upon the pregnant woman. It is crucial to address any potential psychosocial issues along with physiological programs, which can affect maternity care and childbirth experiences. Healthcare providers should understand the perception of maternity care and childbirth experienced by plus-size women. This qualitative study aimed to describe maternity care and childbirth experiences that women who self-identify as obese or plus-size presented in online blogs. This study uses narrative inquiry, following Clandinin and Connelly's framework of the three-dimensional space of temporality, sociality and situation. The study retrospectively collected birth stories posted in blogs by women self-identified as obese or plus-size. A total of 32 blogs were analyzed by employing the thematic narrative analysis mode and following the three-dimensional framework Five major themes and 15 sub-themes emerged, including Struggles and negative feelings*:* a) Self-blame, fears, and guilt related to pregnancy; b) Social bias and stigmatization; c) Plus-size attributed to polycystic ovarian syndrome; c) Weight loss motivation and struggles for a healthy pregnancy. Participation in decision-making: a) Birth plan; b) Involve me in decision-making related to my plan of care; c) Keeping the best interests of my baby first. Empowerment: a) Pregnancy motivates; b) Empowerment by other plus-size women's blogs; c) Reassurance, support, and encouragement by healthcare providers. Respectful care appreciated**:** a) Don't treat me differently because I'm plus-size; b) Less emphasis on plus-

size; c) Finding the healthcare provider and support I deserve. Celebrating the success of the plus-size woman*:* a) Debunking plus-size pregnancy myths; b) Trusting and loving my body. Understanding the perception of the pregnant, plus-size woman will inform healthcare providers on patient-centered care practice, which aims to improve patient/provider relationships, and can contribute to positive maternal fetal outcomes. In order to provide patient-centered care to the obese maternity patient, empathy training, sensitivity training and training in motivational interview techniques for healthcare providers will enhance communication.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

Obesity is one of the most significant health problems that the world faces. Obesity causes health diseases, death, and increases healthcare costs (Centers for Disease Control and Prevention [CDC], 2021). The rising prevalence of obesity in women makes women's health issues even more prominent. As obesity in women increases, the prevalence of maternal obesity is increasing. Obesity during pregnancy affects one in three pregnant women (Jevitt, 2019). In 2019, 29% of women who had live births in the United States were obese during pregnancy (Driscoll & Gregory, 2020). This high prevalence of maternal obesity becomes a significant consideration in maternity healthcare. Obesity in pregnancy increases pregnancy-related physiological risks for both the mother and the fetus, as well as psychosocial risks to the mother, which can impact her maternity care and childbirth experiences.

Statement of the Problem

Maternal obesity is usually defined as having a body mass index (BMI) $\geq$ 30 kg/m^2 at the time of establishing prenatal care until the postpartum period (Fitzsimons et al., 2009). Maternal obesity has risk factors that lead to fetal complications, childhood morbidities, and other complications during the antepartum, intrapartum, and postpartum periods (The American College of Obstetricians and Gynecologists [ACOG], 2015). The complications related to maternal obesity contribute to the maternal mortality rate (Agrawal, 2015; CDC, 2019).

Obesity affects more than an individual's physical health; it also raises a significant psychosocial burden (Kumpulainen et al., 2018; Sarwer & Polonsky, 2016). Obesity stigma is associated with significant physiological and psychological consequences, including depression, anxiety, low self-esteem, and avoidance of medical care (World Health Organization, 2017). So,

it is crucial to address any potential psychosocial issues along with physiological problems among obese pregnant women.

It has been known that women's birth experiences, whether positive or negative, influence maternal psychological outcomes. Their negative experiences result in birth memories filled with anger, fear, sadness, and even postpartum depression or post-traumatic stress disorder (Attanasio et al., 2014; Nilver et al., 2017). The psychological burden of internal or extrinsic negative experiences throughout the antepartum and intrapartum period also increases the risk of poor physical outcomes for both mothers and fetuses (Doyle et al., 2013; Haines et al., 2012).

Research on maternity and childbirth experiences of obese women has recently emerged in the literature. Studies reported obese women's concerns about healthcare providers' weight prejudice (DeJoy et al., 2016; Dinsdale et al., 2016; Flint, 2021; Heslehurst et al., 2013), leading to stigmatization (Cunningham et al., 2018; Dinsdale et al., 2016), patronizing, disrespectful, and humiliating treatment (Alberga et al. 2019; Jones & Jomeen, 2017). Tensions, negative attitudes, and stigmatizing behaviors by maternity healthcare providers while caring for obese women have also been recorded (Bombak et al., 2016; Lauridsen et al., 2018; Mills et al., 2013; Mulherin et al., 2013).

Maternal obesity challenges healthcare providers regarding the risk management of complications, health behaviors, and the provision of patient-centered care. Many providers have expressed feeling overwhelmed and bewildered about offering appropriate care and support to obese pregnant women (Furness et al., 2011; Holton et al., 2017; Schmied et al., 2011). Moreover, communicational difficulties with obese pregnant women have been reported since obesity is a sensitive topic and could lead to stigmatizing behavior on the part of the provider (Furness et al., 2011; Lauridsen et al., 2018; Schmied et al., 2011). In addition, there is a fear of

injury to staff when mobilizing an obese patient. Delivering a baby with an obese mother is physically strenuous and tiring (Knight-Agarwal et al., 2016).

It is noteworthy that weight bias against obesity and obesity stigmatization is prevalent among all healthcare professionals (Alberga et al., 2016; Flint, 2021; Lauridsen et al., 2018). Impact of weight bias and stigma on quality of care and outcomes for patients with obesity included low self-esteem, mistrust of healthcare providers, decreased quality of care avoidance of healthcare, poor health outcomes, and shorter life expectrancy (Alberga et al., 2019; Flint, 2021; Phelan et al., 2015). It is important to note that obese women have indicated their dislike for the term 'obesity' and do not identify as obese women (Atkinson & McNamara, 2017; Lydecker et al., 2016; Volger et al., 2012; Wadden & Didie, 2003). Plus-size is a more popular euphemism (Peters, 2014; Puhl & Himmelstein, 2018; Wadden & Didie, 2003), which had been identified by obese women as a more acceptable term when referring to their body weight. Obese mothers may avoid seeking essential prenatal care from healthcare providers due to the discomfort with weighing and their focus on weight gain (Cunningham et al., 2018; Lingetun et al., 2017). A similar phenomenon is that obese, non-pregnant women are likely to avoid healthcare because of perceived discrimination and bias (McGuigan & Wilkinson, 2015; Mesinger et al., 2018).

Obese pregnant women have expressed their desire for maternity healthcare providers that show empathy, respect, and kindness (Heslehurst et al., 2013). They did not receive encouragement to adopt healthy lifestyle behaviors from their routine maternity care visits (Lavender & Smith, 2015). The lack of consistent, appropriate information and advice from their providers made them confused and anxious (Atkinson & McNamara, 2017).

Though there is ongoing research focused on improving the healthcare management of obese women during pregnancy and birth, there remains a gap in the literature, specifically in identifying any modifiable determinants to improve obese women's experiences in maternal healthcare. More information is needed about how other factors affect obese women's experiences within the maternity healthcare system from a multiple determinants perspective (DeJoy et al., 2016). The identification of such modifiable determinants will aid healthcare providers in identifying strategies to provide high-quality patient care, reduce the risk of adverse events, and improve health outcomes for obese mothers and their infants.

The majority of previous studies conducted patient interviews as a source of data to elicit their participants' views on maternal care experiences. There have been recruitment challenges that could be due to their fear of being judged and scrutinized during their participation (Mills et al., 2013; Tierney et al., 2010). The Internet has become quite popular among pregnant women, and new mothers are primarily motivated to share stories and individual experiences with other women (Maclellan, 2015). As a social media platform, pregnancy and childbirth blogs have been widely used and valued as an online resource for mothers to get information related to pregnancy and birth and social support during pregnancy or postpartum period (Declercq et al., 2013). Research using blogs may serve to overcome the difficulties encountered when attempting to recruit women with weight issues. Because people are more likely to disclose their personal experiences online than offline, anonymity allows bloggers to write honest, candid, and in-depth accounts of their experiences (Fawcett & Shrestha, 2016). Therefore, through the use of blogs, this researcher can adopt a holistic approach while studying the bloggers' experiences (Thomas et al., 2008). Maternity and childbirth stories written by obese women in social media, such as blogs, could bring their natural viewpoint, free from interactions with researchers. This

researcher considered that these blog stories would help identify modifiable factors that influence obese women's perceptions of their experiences with the maternity healthcare system during the antepartum, intrapartum, and postpartum periods.

Purpose of the Study

This qualitative study aimed to describe maternity care and childbirth experiences that women who self-identify as obese or plus-size presented in online blogs and identify temporal, social, and situational factors revolving around their perceptions of their experiences through narrative inquiry.

The research questions were:

1. How do women who self-identify as obese or plus-size perceive their maternity and childbirth experiences?
2. What temporal, social, and situational factors do women who self-identify as obese or plus-size describe in their birth stories that may influence their maternity care and childbirth experiences?

Positionality of the Researcher

As a maternity nurse and an educator teaching maternal and newborn content in an undergraduate nursing program, I am committed to person-centered care. As a maternity nurse, I have witnessed first-hand the conscious and perhaps subconscious bias and stigmatization among nurses and physicians towards obese women during pregnancy and childbirth. As a formerly obese woman, I have also experienced bias and stigmatization in the past. My experiences as an obese woman and a maternity nurse, along with a review of the literature, have led me to the following assumptions:

- Women who identify as obese or plus-size have maternity care and childbirth experiences that are impacted by bias and stigmatization among healthcare professionals.
- Women who are identified as obese or plus-size have experiences impacted by temporal, social, and situational influences.
- Women who identify as obese or plus-size have valuable knowledge to share about their maternity care and childbirth experiences.
- Healthcare providers have an opportunity to learn from the maternity care and childbirth experiences of women who identify as obese or plus-size and have an opportunity to improve the provision of person-centered care for obese women.

In research, it is important not to make assumptions about the perspectives of others. As a researcher, I understand that my positionality is unique to me and could impact all phases of the research study. Throughout the research study, I made every attempt to adopt a reflexive approach and maintain a reflexive journal. The evaluative criteria of credibility, transferability, dependability, and confirmability helped ensure the trustworthiness of this research study.

Theoretical Framework

This study used a narrative inquiry framework, in which stories are studied to understand human actions, experiences, challenges, changes within life events, and the complexities and differences of people's actions (Kim, 2016). People create stories, which help the integration of feelings, perceptions, and reactions in their daily lives (Daiute, 2014; Kim, 2016; Wertz et al., 2011). These stories then become the raw data for narrative inquiry.

Narrative inquirers are interested in experience from an ontological position. Narrative inquiry assumes that throughout experiences, multiple contexts beyond the researcher's control

are always present and describes how individuals make sense of their experiences within these contexts (Clandinin & Connelly, 2000). Dewey's theory of experience (1938/1997) is cited as the philosophical underpinning of narrative inquiry (Clandinin & Connelly, 2000). Fundamental to Dewey's framework of experience are the principles of continuity and interaction. According to Dewey's (1938/1997) description of continuity, every experience builds from previous experiences, and each experience modifies the quality of the experience after. The principle of interaction includes both objective and internal conditions. Dewey posits that interaction is happening between an individual, objects, and other persons. According to Dewey, the principles of continuity and interaction intercept and unite to provide the longitudinal and lateral aspects of the experience.

The narrative inquiry was first introduced in social sciences and has since expanded into education, healthcare, and the humanities (Butina, 2015). Many disciplines have used a narrative inquiry approach to learn about the culture, historical experiences, identity, lifestyle, and particular views of the phenomenon from the experiences of the narrator.

In healthcare, the narrative inquiry has been to collect illness narratives and recognized as an "excellent research method to expand understanding of healthcare provision and individual patient experience" (Joyce, 2015, p. 36). Narrative inquiry in nursing research is "exceptionally useful to uncover nuance and detail of previous experiences" (Wang & Geale, 2015, p. 195). The use of narrative inquiry provides nursing researchers with a "conceptual lens to understand how health and wellness are based in historical and social stories that are constructed on a continuum of being in the world" (Green, 2013, p. 69). The narrative inquiry assists healthcare providers in redefining their practice to better cater to the needs of their patients (Haydon et al., 2018).

Narrative inquiry has also been useful for an in-depth understanding of people's experiences from online stories; since those stories tend to provide thick descriptions, researchers are likely to gather in-depth data (Butina, 2015). In nursing, a few studies used narrative inquiry with online stories. Castro and Andrews (2018) analyzed online nursing narratives to explore the work-life of nurses in anonymous blogs and found three main areas of frustration in nursing jobs: teamwork problems, challenging patient families, and management issues. Castro and Andrews (2018) highlighted the value of this method for gaining insights into nurses' experiences and how these perceptions might be used to inform others. Jaworska (2018) used narrative inquiry to characterize the postnatal depression phenomenon from online stories blogged by women.

Narrative research uses a variety of analytic practices (Creswell, 2013). Several models and modes fall under the family of narrative inquiry methodology. For example, Kim (2016) described several methods of narrative data analysis: Polkinghorne's analysis of narrative, Mishler's models of narrative analysis, and Labov's model. Riessman (2003) described four modes of narrative analysis: thematic narrative analysis, structural narrative analysis, interactional narrative analysis, and performative narrative analysis. In addition to Riessman's description, Smith (2016) added four more modes of narrative analysis: rhetorical narrative analysis, personal narrative analysis, visual narrative analysis, and dialogical narrative analysis.

This study utilized Clandinin and Connelly's (2000) narrative inquiry framework (see Table 1). They evolved Dewey's (1938/1997) theory of experience by defining that a narrative inquiry involves thinking within the three-dimensional space of *temporality*, *sociality*, and *situation*. Temporality refers to what a person brings from the past and present to future experiences. Examples of temporality may include a history of obesity, stigmatization, bias, or weight loss attempts. Sociality involves a person's internal conditions (e.g., feelings, desires,

morals, and hope) and social conditions (e.g., social observations and interactions with people). In this study, sociality included a woman's internal conditions (e.g., expectations, personal feelings, hope, identity, body image, self-esteem) as well as social conditions (e.g., interactions with maternity care providers, the maternity care provided, childbirth, and cultural and social support). Situation refers to the physical setting in which the experiences take place: the places where their experiences occurred, such as clinics, hospitals, birthing centers, or home births. According to Clandinin and Connelly (2000), it is premised that these three dimensions combine and influence the creation of an experience.

Table 1

The Three-Dimensional Space of Narrative Structure

Sociality		Temporality			Situation
Personal	*Social*	*Past*	*Present*	*Future*	*Place*
Look inward to internal conditions, feelings, hopes, reactions, and moral dispositions.	Look outward to existential conditions in the environment with other people and their intentions, purposes, assumptions, and points of view	Look backward to remembered experiences, feelings, and stories from earlier times.	Look at current experiences, feelings, and stories relating to actions of an event	Look forward to implied and possible experiences and plot lines	Look at the context, time, and place in a physical setting with the characters' intentions, purposes, and different points of view.

Note. Adaptated from "Narrative research: A comparison of two restorying data analysis approaches," by J. A. Ollerenshaw and J. W. Creswell, 2002, *Qualitative Inquiry*, *8*(3), 329-347. https://doi.org/10.1177/10778004008003008

In nursing research, Clandinin and Connelly's (2000) framework has been used as an effective means to study people's personal experiences with health and healthcare. The three-dimensional space approach was used to explore adolescents' lived experiences with HIV (Pienaar & Viser, 2012), adjustment to a new lifestyle with long-term survivors of cardiac arrest (Haydon et al., 2018), and older people's hospitalization experiences (Hsu & McCormack, 2011). Haydon et al. (2018) argued that a narrative inquiry from a temporal, social, and situational view would be a gentle relational methodology to uncover what is important to the person in their situation and assist in providing person-centered care in nursing. Hsu and McCormack (2011) argued that narrative research approaches improve the assessment of patient care needs and interactions between patients and their healthcare providers. Therefore, the narrative inquiry, following Clandinin and Connelly's (2000) three-dimensional analytic approach, was chosen for this study to examine the maternity and childbirth experiences of obese women.

Significance of the Study

The patient experience, which relates to the range of interactions that patients have within healthcare, has often been a measurement to determine the quality of patient-centered care (Agency for Healthcare Research and Quality [AHRQ], 2017). Patient-centered care has been advocated since the Institute of Medicine (2001) put it forth as one of the six aims of healthcare quality; it is directly associated with clinical effectiveness and patient safety (Doyle et al., 2013). To provide patient-centered care, healthcare professionals should be respectful and responsive to individual patient preferences and personal, social, and environmental factors unique to each patient (AHRQ, 2018). Obesity is a complex condition with serious social, environmental, and psychological aspects (World Health Organization, 2022). Therefore, it is significant to

understand the maternity and childbirth experiences of obese pregnant women with their previous experiences, social networks, cultural or societal norms, physical environment, physiological factors, as well as situational interactions with healthcare providers. Research on the maternity and childbirth experiences of women who were obese during pregnancy from multifactorial perspective could help healthcare providers improve patient-centered maternity care.

Patient-centered maternity care requires healthcare providers to advocate and collaborate with maternal patients while striving to provide safe and effective care. Healthcare providers have identified the need for more training and expansion of services in the area of support for obese women during pregnancy (Schmied et al., 2011; Wilkinson et al., 2013). For supporting obese women, nurses and other healthcare providers should attempt to understand the nature of their perceptions about their maternity care and childbirth experiences and identify the factors that influence their experiences.

Narrative inquiry, seeking an understanding of how individuals make sense of a process through stories, contributes to a path of knowledge (Green, 2013). By better understanding the complexity and multiple aspects of the patient experience using narrative inquiry, healthcare providers can deliver personalized care (Kirkpatrick, 2008). The information from the narrative inquiry helps healthcare providers develop carefully planned, patient-centered care unique to individual patient needs (Kim, 2016). Therefore, healthcare providers can utilize these findings to improve interpersonal behavior, communication with obese women, and patient-centered care provision to obese pregnant women for achieving better maternal and fetal outcomes.

The use of stories shared by obese women about their maternity care and childbirth experiences in online blogs presents an innovative approach in gathering and capturing the data

of such experiences. This approach offers several advantages in research. First, the shared stories included diverse, dynamic factors influential to maternity and childbirth experiences from an individual perspective. Twenty-five percent of the 7.5 billion people in the world use social media (Chaffey, 2017). Blogging is a popular method for sharing and reflecting on personal experiences (Pinilla et al., 2013). It serves as a powerful platform for emotional and informational release, satisfying the need for self-expression (Carson et al., 2016; Jones & Alony, 2008). Women sharing their birth stories in online blogs provide naturalistic data from a first-person viewpoint rather than a predetermined focus by research instruments or structured interview questions (Hookway, 2008; Thomas et al., 2018). Each woman's pregnancy and birth stories reflect the distinctive nature and perception of their experiences. The telling or writing of stories that describe a woman's pregnancy and birth experience is a common social practice among many cultures (Carson et al., 2016). Blogged stories have been sources for learning and empowering each other (Blainey & Slade, 2015; Reed, 2011).

Second, data collection from online birth stories allowed access to broader populations, including those in which face-to-face encounters could have been objectionable (DePoy & Gitlin, 2016). Past studies related to the experiences of obese women have described difficulties with recruitment and retention. Perhaps obese women are offended about inclusion criteria based on their classification of obesity or are fearful of being judged or cast in a negative light. Some women may not want to talk about obesity as it is a sensitive topic (Tierney et al., 2010). In a study (Jaworska, 2018) with online stories about postnatal depression as blogged by women who had experienced the phenomenon, online narratives were useful as they enabled women to tell the "untellable" in an anonymous digital environment, servicing as a safe space for women to

share personal, intimate stories of their lives. Otherwise, in a vulnerable position, these women may not have shared their stories.

Blogs are considered a newer form of accessible data that offer unique insight and understanding of the healthcare experiences of patients (Clark & van Amerom, 2008; Thomas et al., 2018). Understanding of maternal and birth experiences can be drawn from birth stories written in online blogs by women who self-identified as obese or plus-size during pregnancy. Diverse personal, social, situational, or temporal factors that may have affected women's perceptions of maternity and birth experiences could be identified through blogged stories' rich and deeply personal accounts.

Chapter Summary

The rising epidemic of obesity among childbearing women becomes a significant consideration in maternity healthcare. Obese women face many physical and psychological burdens during pregnancy, often leading to poor pregnancy and birth outcomes. Although there have been studies examining the maternity experiences of obese women, in order to reduce their negative experiences and improve person-centered maternity care, a deeper understanding of their maternity and childbirth experience is needed in consideration of temporal, social, and situational influences. The use of stories shared by obese or self-identified plus-size women about their maternity care and childbirth experiences in online blogs presents an innovative approach to gathering and capturing the data of such experiences. Using the narrative inquiry using Clandinin and Connelly's (2000) three-dimensional space framework allows this researcher to have a broad, in-depth understanding of the maternity care and childbirth experiences of obese or plus-size women. Exploring blogs utilizing narrative inquiry would give healthcare providers greater insights into obese women's maternity experience during pregnancy.

The findings will assist healthcare providers in devising their approaches and performances towards high-quality, patient-centered care to obese or plus-size pregnant women and the prevention of adverse maternal and birth outcomes caused by negative maternity and birth experiences.

CHAPTER II

LITERATURE REVIEW

This chapter begins with a review of the literature on maternal obesity and its effects on maternal, fetal, and newborn health. This chapter also includes a review of the literature on maternity and childbirth experiences of obese women and gaps in the previous research. A literature search using the Texas Women's University library databases was first conducted in 2018, with keywords related to maternal obesity and pregnancy and childbirth experiences with limitations to include the English language, peer-reviewed articles between 2013 and 2018. Later, articles published after 2018 were also included in the literature review.

Maternal Obesity Impacts on Maternal, Fetal, and Neonatal Outcomes

Pre-pregnancy obesity and maternal obesity have significantly impacted multiple adverse maternal, fetal, neonatal, and childhood outcomes. These outcomes vary for different phases of pregnancy and childbirth, such as pre-conception, antepartum, intrapartum, postpartum, neonatal, and childhood.

Preconception

In the pre-conception period, obesity decreases fertility in women (Broughton & Moley, 2017; Talmor & Dunphy, 2015). Obese women who seek fertility treatment tend to face BMI limits or limited options for treatment (Kelley et al., 2019). Even if women obtain fertility treatments, the efficacy of the treatments is still low (Provost et al., 2016).

Antepartum

Obesity in pregnancy increases hypertension and preeclampsia (ACOG, 2015; Stubert et al., 2018; Vernini et al., 2016; Wei et al., 2016), gestational diabetes mellitus (ACOG, 2015; Stubert et al., 2018; Wei et al., 2016), and obstructive sleep apnea (ACOG, 2015). Pre-pregnancy

obesity increases the risk of congenital anomalies of the fetus and spontaneous miscarriage (ACOG, 2015; Stubert et al., 2018). The risk of stillbirth is increased by pre-pregnancy obesity and pregnancy comorbidities (ACOG, 2015; Liu et al., 2016; Stubert et al., 2018). Furthermore, a high pre-pregnancy BMI increases the risk of antepartum depression and anxiety (Holton et al., 2019).

Intrapartum

Women with pre-pregnancy obesity are more likely to experience preterm labor and birth (Stubert et al., 2018). The risk of epidural failure increases with the technical difficulties in placing the epidural due to the loss of landmarks related to the obese body (ACOG, 2015; Stubert et al., 2018). Furthermore, following epidural anesthesia, obese women have more incidents of maternal hypotension and prolonged fetal heart rate decelerations (ACOG, 2015). When induced for labor, obese women are more likely to have a failed trial of labor (ACOG, 2015; Stubert et al., 2018) and an increased risk for cesarean delivery (ACOG, 2015; Stubert et al., 2018; Wei et al., 2016).

Postpartum

Obese women have a higher risk of postpartum hemorrhage (Wei et al., 2016), postpartum infection (Stubert et al., 2018), wound rupture or dehiscence, and thromboembolism (ACOG, 2015). The risks may contribute to a more extended hospital stay (Vernini et al., 2016), higher hospital costs of childbirth (Solmi & Morris, 2018), and elevated postnatal mortality risk (Stubert et al., 2018). Obese women are more likely to have delayed breastfeeding initiation (Pinheiro et al., 2018) and early termination of breastfeeding (ACOG, 2015). Postpartum weight retention and future metabolic syndrome also become more likely after pregnancy (ACOG,

2015). Additionally, women who were obese during pregnancy are more likely to suffer postpartum depression (ACOG, 2015).

Neonatal

Infants born to obese women are more likely to develop macrosomia. Macrosomia is defined as weight greater than 8 pounds and 13 ounces (ACOG, 2015; Liu et al., 2016; Vernini et al., 2016; Wei et al., 2016; Zhao et al., 2018). Infants of obese women are at higher risk for admission to the neonatal intensive care unit (Liu et al., 2016).

Childhood

Childhood morbidities also increase when mothers are obese during pregnancy. Children have a higher risk of developing metabolic syndrome and childhood obesity (ACOG, 2015; Stubert et al., 2018). Pre-pregnancy obesity and excessive weight gain during pregnancy place children at a higher risk for autism (Windham et al., 2019), childhood developmental delays, and attention-deficit/hyperactivity disorder (ACOG, 2015).

There are mixed reports across previous studies regarding obese women's awareness of pregnancy and childbirth risks. Some obese women were aware of the risk of developing comorbidities and complications with the pregnancy (Relph et al., 2021). However, some women claimed that they were unaware of any risks associated with obesity during pregnancy (Lavender & Smith, 2015; Relph et al. 2021). Other women stated that they lacked knowledge regarding complications for both mother and baby (Knight-Agarwal et al., 2016; Relph et al. 2021) or the need for additional tests and surveillance associated with their weight (Cunningham et al., 2018). Women's knowledge of pregnancy risks associated with maternal obesity influences the choices they make regarding their antepartum and intrapartum care (planning for labor and birth). While it is important to provide education and counselling regarding risks associated with maternal

obesity, there exists a delicate balance to ensure information is provided in an acceptable and sensitive manner (Jones & Jomeen, 2017; Relph et al., 2021).

Pregnancy and Birth Experiences of Obese Women

This researcher conducted a literature review of the experiences of obese women as they navigate the maternity system. The literature search was performed through EBSCO databases. The following search terms and Boolean operators were used: obesity AND (pregnancy OR childbirth) AND (experiences OR perceptions OR attitudes OR views). The inclusion criteria were peer-reviewed articles written in English. After reviewing all relevant articles, a secondary review was performed by searching for cited references from the first identified articles. This literature selection process identified 15 studies on maternity experiences published between 2013 and 2018. The majority (n = 14) of the studies used a qualitative design, and one used a quantitative design. There was only one study conducted in the United States (DeJoy et al., 2016); six studies took place in the UK, three in Sweden, two in Australia, one in Canada, one in Ireland, and one in Denmark. Out of 14 qualitative studies, 13 used face-to-face or telephone interviews with sample sizes ranging from 10 to 34 participants.

First, a noteworthy finding common across studies was that the terminology surrounding the obesity diagnosis was a sensitive issue among many obese women during pregnancy. Many women dislike the term *obese* (Atkinson & McNamara, 2017; Bombak et al., 2016; Cunningham et al., 2018; Heslehurst et al., 2013). Other terms such as *fat* were also considered unacceptable. Some women reported that these terms were deemed to be personal and degrading (Cunningham et al., 2018).

Second, studies have found that the weight-focused interactions by healthcare providers affected obese women's emotions and maternal service-seeking behaviors. Discussions

surrounding their weight were unhelpful and judgmental (Knight-Agarwal et al., 2016; Mills et al., 2013). Some obese women reported discomfort about being weighed and the focus on weight gain, causing them to consider not attending their healthcare appointments for that reason (Cunningham et al., 2018; Lingetun et al., 2017). On the other hand, following childbirth, obese mothers were surprised that their providers avoided discussing their weight and weight management (Atkinson & McNamara, 2017; DeJoy et al., 2016; Jones & Jomeen, 2017; Knight-Agarwal et al., 2016; Lavender & Smith, 2015; Mills et al., 2013). Some obese women reported that their risks made it challenging to access healthcare providers and the type of birth they desired; for instance, obese women felt compelled to have epidurals or cesarean deliveries, based on the assumption that they were prone to operative births and complications (DeJoy et al., 2016). Decisions regarding the obese women's candidacy for delivery in a less medicalized birthing center were based solely on their weight rather than other health factors (Mills et al., 2013).

Obese women reported discomfort encountered during the examination due to clothes or equipment not being size-appropriate, including blood pressure cuffs, patient gowns, and disposable postpartum panties (DeJoy et al., 2016). This discomfort may prevent them from receiving the same care that might be provided to a woman with a healthy BMI (Mills et al., 2013).

Lastly, previous research has found obese pregnant women's feelings of humiliation, self-blame, and guilt for putting their fetus at risk and disappointment, helplessness, and skepticism toward their maternity healthcare providers. Many women with maternal obesity reported experiencing mother-blame when healthcare providers discussed fetal risks and often felt reprimanded for their high-risk pregnancy (Bombak et al., 2016). Some obese women

reported receiving advice from healthcare providers not to get pregnant or refusal to treat infertility due to concerns that their weight could put a potential fetus at risk (Bombak et al., 2016; DeJoy et al., 2016). Some obese women reported an overwhelming fear of complications, resulting in anger towards their healthcare providers (DeJoy et al., 2016, Relph et al., 2020). Some women felt singled out and automatically labeled a high-risk pregnancy based on their weight alone, despite experiencing no other complications; they were transferred to a high-risk care unit regardless of no complications (Lauridsen et al., 2018; Lingetun et al., 2017).

Many women reported stigmatizing behaviors from their maternity healthcare providers along with adverse treatment (Bombak et al., 2016; Heslehurst et al., 2013). Many women felt that their healthcare providers persistently made negative comments about their weight, reporting insensitive, hostile, and humiliating comments and interventions (DeJoy et al., 2016). Obese women felt that their healthcare providers judged them, creating feelings of alienation, being less worthy, and less respected than other pregnant women who were not obese (Relph et al., 2021). Some of the women felt that their birth plans were ignored or disrespected (Bombak et al., 2016). They did not question their treatment due to the fear of not receiving adequate care or denial of care (Bombak et al., 2016; Olander, 2020).

Gaps in the Literature on Pregnancy and Birth Experiences of Obese Women

It is critical to examine all the factors involved in maternity care and childbirth experiences, particularly the patient experience, which is recognized as a means of assessing the quality of healthcare delivery and patient-centered care (Edwards et al., 2014). There has been continual improvement through research on healthcare management of obese women during pregnancy and birth. However, previous research has shown a gap in identifying potential moderators that could improve obese women's experiences in maternal healthcare.

Most previous qualitative studies examining the obese woman's experience collected data from interviews, relying on patient recruitment and willingness to participate. Therefore, there could be missing information in the experiences of obese women as some may not wish to be individually recruited for a research study on obesity during pregnancy. Some participants may not be comfortable discussing sensitive aspects of their experience with another individual. In addition, when interviewing participants in research studies, the questions provided may be limited and therefore may not uncover data that could shed light on issues that have not been considered to affect the woman's experiences, whether positive or negative.

It is important to capture information about how other factors affect the way women experience (DeJoy et al., 2016). By gaining an understanding of the obese woman's maternity and childbirth experiences based on her own narrative without a predetermined focus, there is an opportunity to get a glimpse of sources within and outside the woman that gives rise to the experience and perceptions of experience and may be essential in providing patient-centered care by informing practices through the subjective and objective conditions within their pregnancy and maternity care experiences. The use of birth stories, which were self-directed and self-written by women who identify as obese or plus-size, can provide a different approach to gathering data using a narrative inquiry framework. These stories provide valuable information about their experiences from a naturalistic perspective. Gathering data without the use of traditional patient recruitment and participation may also provide valuable information that has not been shared by obese women due to difficulties in recruitment and participation of women regarding the sensitive topic of weight (Tierney et al., 2010), especially considering that women may not want to be targeted as an obese woman (Lauridsen et al., 2018). Birth stories posted on blogs are one source to gather information about experiences, perceptions, and feelings (Wilson

et al., 2015). Online blogs allow qualitative researchers to understand the perceptions of complete experiences of people through their personal accounts (Castro & Andrews, 2018; Keim-Malpass et al., 2013)

Birth Stories

Pregnancy and birth are often recognized as important and pivotal life experiences. Many women use birth stories to share their experiences with others, using their personal narratives as part of common and social practice (Bylund, 2005; Callister, 2004; Carolan, 2006; Carson et al., 2016; Farley & Widman, 2001). Women have shared their stories through various methods, verbally, in writing, and via the Internet (Reed, 2011).

Women describe various reasons for sharing their stories and benefits from sharing their experiences. Through sharing their stories, some women can distance themselves from the experiences and reframe their experiences into a narrative (Blainey & Slade, 2015). Mothers are often eager to share their pregnancy and birth experiences to playback the details of their experiences and define the meaning of their experiences (Callister, 2004). Birth stories may create a sense of connection to other women who have given birth (Callister, 2004). Women's birth stories are considered relevant data for research. Multiple studies have used them to access maternal experience among several groups and populations (Carolan, 2006). Using individually driven birth stories as a source of data reduces the interview bias that may occur in the research relying only on patient interviews (van Stenus et al., 2017).

Birth Stories Posted in Online Blogs

Using the Internet has become quite popular. In 2020, it was estimated that there were 37.1 million bloggers in the United States, accounting for up to 10% of the population (Chang, 2022). Pregnant women and new mothers are motivated by sharing stories of individual

experiences with other women (Maclellan, 2015) and have reported benefits from writing about their birth stories and emotional experiences online, such as through blogs (Blainey & Slade, 2015). According to a national survey as part of an ongoing *Listening to Mothers*' initiative, pregnancy and childbirth blogs were the most frequently used and valued online resource for mothers (78%) who used them as pregnancy and birth information sources (Declercq et al., 2013).

Personal blogs can be a valuable data source for researchers investigating human health experiences (Eastham, 2011; Snee, 2013). Individuals use blogs to share their personal experiences, expand their knowledge, seek opinions, and provide validation and emotional support (Keim-Malpass et al., 2013). Thus, the personal nature of blogs provides the researcher an opportunity to investigate the thoughts and feelings of others (Chenail, 2011). Blogs can better inform healthcare interventions and policies by understanding patient issues and behaviors that may not be obtained using traditional research data (Simoni et al., 2014). For example, Thomas et al. (2018) used blogs to explore the lived experience of life after a stroke, while Shapira et al. (2017) conducted a content analysis of Parkinson's patients' blogs, and Heilferty (2018) addressed meaning and performance in illness blogs. The authors of these studies determined that blogged narratives allowed the researchers a new level of involvement and inclusion (Thomas et al., 2018) and provided a comprehensive information source (Shapira et al., 2017). Blogged narratives helped the researchers answer their studies' research questions and explore lived experiences (Heilferty, 2018; Shapira et al., 2017; Thomas et al., 2018). Moreover, blogs allow qualitative researchers to understand the perceptions of complete experiences of people through their personal accounts (Castro & Andrews, 2018; Keim-Malpass et al., 2013). Research using blogs helps overcome difficulties encountered when attempting to recruit

pregnant women with weight issues. Obesity and pregnancy are sensitive topics. Challenges in recruitment may be due to the woman's fear of being judged and scrutinized through their research participation (Mills et al., 2013; Tierney et al., 2010). Individuals are more likely to disclose their personal experiences in online settings than offline if anonymity is guaranteed.

The anonymity makes the blogger more likely to write honestly and candidly about their experiences while providing rich, detailed personal first-hand accounts (Fawcett & Shrestha, 2016). Additionally, collecting data from blogs using a retrospective approach prevents data from being influenced by the researcher (Moore et al., 2016). Blogs are a data collection method to primarily gather information about experiences, perceptions, and feelings (Wilson et al., 2015).

Chapter Summary

For patient-centered care, it is necessary to understand the patient experience in depth. This chapter described the impacts of maternal obesity on maternal, fetal, and neonatal outcomes and presented a review of the literature on prenatal, childbirth, and postpartum experiences of obese women during pregnancy. Based on the literature review, it was noted that more information is needed to identify moderators, which may negatively or positively influence the perceptions of obese women's perceptions of their experiences that might not be captured in prior qualitative studies due to limitations in obtaining participation in qualitative research studies or through the use of interview sources of data. More information is needed about how other internal and external factors, such as social, temporal, and spatial experiences, influence obese women's experiences with maternity care and childbirth.

Birth stories are an excellent source for the narrative inquiry into the experiences of obese women. Many women share their birth stories in online blogs. Prior research related to patient

experiences of illness has utilized blogs for data collection and analysis, especially with patient populations that are harder to recruit for the study. The use of blogged birth stories would be an innovative way of capturing maternity care and childbirth experiences among obese women from their naturalistic viewpoint. Blogged birth stories could create a greater sensitivity among healthcare providers on the intricacy of these women's experiences towards quality maternity care.

CHAPTER III

METHODOLOGY

This chapter presents the methodology used in this research study. It provides information on the study design, sample, data collection procedure, and data analysis. The chapter also describes ethical considerations, scientific rigor, and limitations.

Study Design

This qualitative study used narrative inquiry to describe the pregnancy, maternity care, and childbirth experiences that women who self-identify as obese or plus-size posted in their online blogs and identify temporality, sociality, and situational factors contributing to their experiences. This narrative inquiry study employed the thematic narrative analysis mode described by Riessman (2003) and followed Clandinin and Connelly's (2000) three-dimensional space framework.

Sample

The study retrospectively collected birth stories posted in blogs by women who identified as obese or plus-size during pregnancy and throughout their maternity and childbirth experiences.

Data Collection

A Google search was conducted using the keywords *birth stories* AND *blogs*. The initial results were further filtered through advanced search settings using the following keywords and Boolean operators, *obese* OR *plus-size*. Plus-size was used as a search term since obesity is a medical term and women who fall within the BMI classifications of obesity reject the medical definition of obesity (Ellis et al., 2014). Plus-size is a more popular euphemism (Peters, 2014). In the fashion industry, plus-size apparel is designed for women whose girth exceeds the average

compared to women of similar height (Romeo & Lee, 2015). The term plus-size is relevant since it is more likely to be used than obese.

Through the Google search on August 11, 2018, 279,000 results were revealed. The first result showed a collection of plus-size birth stories from a website titled Plus-Size Birth (Plus Size Birth (n.d.) Next, an advanced search setting was applied for English site results, showing the most relevant results and containing updates posted since 2017. Based on the first 50 results, Plus-Size Birth was the only website with a collection of plus-size birth stories. Plus-Size Birth has a blog site for plus-size mothers to share information and provides an array of plus-size birth stores.

Upon further exploration, Plus-Size Birth has been identified as one of the best pregnancy blogs according to Healthline (Timmons, 2019), Medical News Today (Nichols, 2017), and Feedspot (2019). Within these rankings, Plus-Size Birth is the only pregnancy blog that focuses on women's unique challenges when they are plus-size and pregnant. The founder of Plus-Size Birth recognized that plus-size women were underrepresented in the mommy blogging community (Timmons, 2019).

At the time this search was conducted, 44 birth stories were posted in the blog and reviewed. The inclusion criteria for this study were birth stories about pregnancy, maternity care, or childbirth experiences, written first hand in English by women who self-identified as obese or plus-size. All blogs met the inclusion criteria.

Sample Size Justification

A total of 32 birth stories blogged within Plus-Size Birth (n.d.) were analyzed for this study. These blogs were chosen for the richness of the stories. In qualitative research, the validity, meaningfulness, and insights have more to do with the richness of the cases (Patton,

2015). The review of previous studies analyzing blogs indicated that sample size ranged from 10 to 22 blogs (Fawcett & Shrestha, 2016; Garbett et al., 2017; Heilferty, 2018; Shapira et al., 2017; Thomas et al., 2018). There was no definitive sample size for studies of blog analysis.

Saturation has been used as a criterion for discontinuing data collection and analysis in qualitative research, which determined the sample size. Saunders et al. (2018) described four different models of saturation based on the principle foci in the research process while also suggesting hybrid forms of saturation. These saturation models are theoretical saturation, inductive thematic saturation, a priori thematic saturation, and data saturation. A priori thematic saturation points to the degree to which identified codes are exemplified in the data. Data saturation relates to the degree to which new data repeat what was expressed in previous data. Since data were plotted within Clandinin and Connelly's (2000) three-dimensional space, this study applied the hybrid form of a priori thematic saturation and data saturation. All available blogs were considered for data analysis, and the appropriate sample size was assessed as the study progressed.

Data Analysis and Synthesis

Analytic approaches to narrative inquiry vary widely depending on different perspectives and strategies for interpretation (Savin-Baden & Van Niekerk, 2007). The analysis method for this study was thematic narrative analysis described by Riessman (2003), which emphasizes the content of the stories rather than how the stories are told or written. Thematic narrative analysis was therefore appropriate for this study, which aimed to describe maternity care and childbirth experiences that obese women perceive and present on their online blogs and to identify social, temporal, and situational factors revolving around their perceptions of their experiences.

In a thematic narrative analysis, themes can be determined either deductively by applying a priori themes derived from a framework or inductively from the data (Jones & Lynn, 2018). When deciding on an inductive or deductive analysis method, this researcher considered the purpose of the research and the methods best suited to answer the specific research questions. This study used both deductive and inductive methods of theme development, following the narrative inquiry framework endorsed by Clandinin and Connelly (2000).

First, this researcher familiarized herself with the data by reading and rereading the blog scripts. An approach to broadening was used to look for a broader context of each story. This researcher made notes about general descriptions of the storyteller's characteristics and values within the social, temporal, and environmental milieu (Connelly & Clandinin, 1990). An approach to burrowing was also used to focus on more specific details such as the storyteller's feelings, understandings, and how certain events influence the storyteller's surroundings (Connelly & Clandinin, 1990). Themes were first determined deductively from sentences or paragraphs in the individual blogged birth stories and recorded according to the Clandinin and Connelly (2000) framework of the three-dimensional space—sociality, temporality, and spatiality. Ollerenshaw and Creswell (2002) recommended using a narrative structure table to plot the narrative data. Individual narrative scripts (e.g., sentences or paragraphs) from the blogged stories were plotted into the three-dimensional space. Table 2 presents an example of blogged scripts plotted in the three-dimensional space using the narrative structure table. Simultaneously, this researcher wrote analytic memos about the narratives. This researcher remained open to adding new dimensions and alternative ways of thinking about the events described in the stories.

Table 2

Examples of Citations from Blogs Plotted in the Three-Dimensional Space Narrative Structure

Sociality		Temporality			Situation
Personal	*Social*	*Past*	*Present*	*Future*	*Place*
"I do best when I feel in control and understand what is happening and why."	"I trusted my midwife and her judgment. I had known her for almost 7 years - she had been delivering children for nearly 30 years, and I respected her experience. I didn't need to fight her or convince her of my desire to have a low-key birth."	"My last pregnancy triggered PTSD due to interventions and loss of control."	"This body that I'd hated for 32 years was all of a sudden a freakin' HUMAN MAKER. What better superpower is there in this life?"	"Unless I don't turn up with gestational diabetes next time or any other high-risk problem (other than age), I will definitely not step foot in the hospital again without the biggest, meanest doula I can find."	"I found this environment to be safe and was able to labor in peace."

Second, an inductive approach to thematic narrative analysis was employed. In narrative inquiry, a thematic approach finds common thematic elements among a range of research participants' shared experiences (Riessman, 2003). Braun and Clarke (2006) stated, "a theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set" (p. 10). The thematic narrative analysis emphasizes similarities and differences across the body of data, often leading to unanticipated insights (Braun & Clarke, 2006).

This researcher looked across the individual narrative scripts plotted within the three-dimensional space and considered which resonant threads or patterns could be discerned. This

researcher continued to read the blogged birth stories, making notes of words or short phrases, and creating a summary statement to reflect what was being said in the stories. Further, this researcher collected the created summary statements to identify higher-level categories. Then this researcher reviewed all the words and phrases from all the birth stories and worked through them, removing redundancies and reducing the number of categories. After that, this researcher looked for overlapping and similar categories to group together within a theme and attempted to discover, verify, and confirm additional themes.

Following inductive thematic narrative analysis, this researcher sought an appropriate peer review using another suitably experienced researcher. The peer reviewer independently reviewed and explored the scripts of the blogged birth stories, plotted the data within the three-dimensional space, and created additional themes. After the independent review, this researcher and peer reviewer met to discuss the findings. This researcher sought honest feedback to benefit from the peer review, preventing bias and potentially gaining new insights into theme development (Burnard et al., 2008). This researcher sought additional feedback on whether themes appeared appropriate to inform the research question. The researcher remained open to alternative points of view and carefully considered the peer reviewer's feedback. This researcher accepted final responsibility for the study results and implications.

The final phase was to produce a scholarly report of the analysis. This researcher first selected vivid and compelling excerpts of blog scripts. Then this researcher prepared a presentation of the analysis procedure and findings and related these back to the research questions and literature review.

Ethical Considerations

The Plus-Size Birth (n.d.) blog is available in the public domain, and permission was obtained from the founder to use the birth stories content for research purposes. This researcher made all efforts to protect and preserve the anonymity of the bloggers by removing any identifying information. This study obtained approval for exempt research from the Texas Woman's University's Institutional Review Board.

Treatment of Data

Screen shots of birth stories were copied and pasted into a Microsoft Word document along with blogged birth stories. Names included in the analysis were changed to enhance privacy. The blogged birth stories were then copied from the Microsoft Word document and pasted in NVivo 12 on a personal, password-protected computer, in which only the researcher and the research dissertation chair had access.

Scientific Rigor

The scientific rigor in qualitative studies is examined through trustworthiness (Golafshani, 2003; Krefting, 1991). Trustworthiness reflects internal validity, external validity, reliability, and objectivity (Lincoln & Guba, 1985). In qualitative research, Lincoln and Guba (1985) replaced these terms with new terms that were felt to be a better fit for naturalistic data: (a) credibility (internal validity); (b) transferability (external validity); (c) dependability (reliability); and (d) confirmability (objectivity). The evaluative criteria of credibility, transferability, dependability, and confirmability ensured the scientific rigor of this research study.

Credibility

Credibility refers to the level of confidence placed in the truth of the research findings (Lincoln & Guba, 1985). This researcher demonstrated prolonged engagement by allowing enough time to read and reread the blogged birth stories to increase the likelihood of credible findings. This study methodology involved collecting blogged birth stories using a retrospective approach. This data collection process strengthened credibility, as this researcher had no influence over the data (Moore et al., 2016). As an additional measure to support credibility, peer review was used during the data analysis process to evaluate the data collection process and analysis through a new set of eyes. This reduced concerns about any potential bias of this researcher.

Transferability

Transferability refers to the degree to which the findings of a qualitative research study can be transferred to other contexts, settings, and other respondents (Lincoln & Guba, 1985). Using thick description is a strategy to enhance transferability criteria (Lincoln & Guba, 1985). Rich and thick descriptions contextualize the stories, allowing the reader to determine to which extent their own situations match the research context (Merriam, 2002). This study used blogged birth stories for data collection and analysis. The advantage of using blogged birth stories for data lies in the anonymity of vulnerable individuals who might not wish to share their stories face-to-face with this researcher. Rich and thick descriptions of the events in these blogged birth stories and the use of verbatim quotes to underpin the thematic narrative analysis provided verisimilitude, enabling the reader to visualize how their situations match the context of the study.

Confirmability

A confirmability audit is considered an effective strategy for establishing confirmability (Lincoln & Guba, 1985). Throughout the research process, a transparent description of all research steps was described in an audit and reflexive journal. This researcher documented all raw data and kept notes regarding the decisions made during the research process, including data collection decisions, reflexive notes, research meetings with the peer reviewer, emergence of findings, and all information regarding the data management.

Dependability

Dependability evaluates the integrity of the qualitative study (Lincoln & Guba, 1985). This researcher ensured that the analysis process conformed to the accepted standards for qualitative narrative inquiry. This researcher repeatedly reviewed the blogged scripts and analysis results over time, and all revisions of analysis were recorded and reviewed in a study journal to reflect the integrity of the study.

Chapter Summary

This chapter presented the study methodology. Plus-Size Birth (n.d.) is a website containing a collection of blogged birth stories by plus-size women, identified via a Google search. At the time of the Google search, this blog website held 44 birth stories; however, a total of 32 birth stories were included in data analysis as these blogs contained the richness of the stories. The data analysis used a hybrid of deductive and inductive thematic narrative analysis, following the narrative inquiry framework of Clandinin and Connelly (2000). This researcher first plotted the narrative scripts of the blogged birth stories within the three-dimensional aspects of temporality, sociality, and space. Then, the plotted scripts were analyzed to draw themes in an inductive approach to thematic narrative analysis. Appropriate strategies were used to ensure the

scientific rigor of this study, including credibility, transferability, dependability, and confirmability.

CHAPTER IV

RESULTS

Introduction

Chapter 4 presents the findings from the narrative inquiry analysis with a total of 32 birth stories blogged on the Plus-Size Birth website. The three-dimensional narrative inquiry framework by Clandinin and Connelly (2000) was used to describe how plus-size women perceived maternity care and childbirth experiences interrelated with social, temporal, and situational factors. This chapter begins with a brief description of the sample, including the number of births, types of healthcare providers, places of birth, mode of delivery, and pain management techniques during labor. The chapter then presents five major themes with 15 sub-themes regarding plus-size women's maternity and birth experiences, including social, temporal, and situational factors.

Description of the Sample

Of the 32 birth stories, 21 women were primiparous (pregnant women giving birth for the first time), and 11 were multiparous (women who previously gave birth). Fifteen women (BS 3, 4, 5, 7, 9, 10, 12, 13, 15, 24, 25, 26, 36, 41, and 44) chose an obstetrician/gynecologist (OB/GYN) as their healthcare provider throughout pregnancy and childbirth; nine women (BS 1, 2, 3, 18, 21, 22, 28, 33, and 37) chose a midwife. Five women (BS 14, 16, 23, 31, and 45) started antenatal care with an OB/GYN and switched to a midwife mid-pregnancy. In contrast, two women (BS 6 and 14) had an OB/GYN and a midwife provider. One woman (BS 34) did not identify the type of healthcare provider throughout pregnancy and birth.

Twenty-five births took place in the hospital center, including one transferred from a birth center to a hospital. Five women (BS 2, 8, 16, 18, and 22) gave birth in birth centers, with

one (BS 18) transferring to a hospital after birth due to complications. One of the five birth centers was within a hospital. One woman (BS 28) gave birth at home as planned, and one woman (BS 34) did not identify her birthing location. Eighteen births were through spontaneous vaginal deliveries (SVD), and one (BS 18) was a vacuum-assisted vaginal delivery (VAVD). Four births (BS 2, 17, 21, and 36) were successful vaginal births after cesarean (VBAC). The women desired a trial of labor due to the previous child being born via cesarean section. Eight births (BS 3, 9, 10, 12, 23, 24, 25, and 33) were primary cesarean deliveries, and one delivery (BS 44) was a repeat cesarean section after having a prior cesarean section.

Nineteen women had birth plans, and seven women (BS 2, 8, 16, 21, 22, 33, and 45) had a doula to help them through labor and birth. Eleven births involved non-pharmacological interventions for pain management (i.e., breathing techniques, position changes, birthing balls, hydrotherapy, music therapy), and three deliveries (BS 18, 33, and 41) involved non-pharmacological interventions and nitrous oxide administration. Inhaled nitrous oxide (N_2O) provides a non-invasive option to help with pain management in laboring women. Nitrous oxide is often equated by women to be consistent with natural childbirth, providing benefits that include relaxation, distraction, and the ability to focus on breathing techniques (Richardson et al., 2018).

Thirteen births involved regional anesthesia during delivery, although five of these births were initiated with non-pharmacological intervention plans. One labor (BS 12) involved non-pharmacologic interventions, regional anesthesia, and then general anesthesia for effective pain management during cesarean delivery. Four blogs (BS 7, 23, 25, and 27) did not describe the type of pain management used during labor and birth. Eleven women had their labor medically induced, and two women (BS 17 and 18) had their labor medically augmented.

Findings

This study found that plus-size women described experiences interrelated with many social, temporal, and situational factors. Five major themes and 15 subthemes emerged from plus-sized pregnant women's perspectives.

Theme 1: Struggles and Negative Feelings

This theme relates to both the temporality commonplace related to women's past experiences brought forth to their plus-size pregnancy and childbirth experiences and the sociality commonplace in which the women described their personal conditions related to their feelings. This theme embraces plus-size women's postings about their self-blame, fear, and guilt related to their pregnancy, perceptions of social bias and stigmatization, struggles with polycystic ovarian syndrome (PCOS), their attempts at weight loss, and struggles for a healthy pregnancy.

Self-Blame, Fears, and Guilt Related to Plus-Size Pregnancy

Many women posted expressions of "fear," "nervous," "scared," "worried," "horrible," "terrified," "fault," "anger," "confusion," and "guilt" within various personal and situational factors. For example, Patricia (BS16) described her fear about seeing a healthcare provider when she was pregnant, stating:

> "I was a little nervous since I was at 257 lbs. I was heavier than I had planned on being at the start of my pregnancy. I immediately wondered what the doctor would say, how providers would treat me, and if I would have any complications."

Quinn (BS18) described her fears of stigmas, stating:

> I began seeing the midwives at a local women's clinic. As a fat woman, I feared the stigmas." Susan (BS22) expressed fears of gaining more weight during pregnancy:
>
> "Going into my pregnancy, I was already several pounds heavier than I felt comfortable

at and was scared that it was only up from there. In the beginning, I constantly worried about my health.

Some women were worried about complications. Jenna (BS10) posted, “Let me first say that I was terrified of being pregnant. I thought that because I was plus-size, I couldn’t have a healthy pregnancy.” Nina (BS14) wrote, “…waffled between anger, confusion, and guilt. It felt like my body wasn’t healthy enough to safely carry.” Brianna (BS34) wrote, “Right off the bat, I knew I was going to have a horrible pregnancy just because of my size.” Also, “I automatically assumed I would be diagnosed with gestational diabetes.”

In the events that labor and birth did not go as planned, several women blamed their weight and size. Cara (BS3) wrote, “I was so done with labor. I was overthinking everything. Would this be easier if I wasn’t plus-sized? Is my weight hurting my baby? Could I have done anything differently?” Zenoba (BS31) noted, “All I could think about was the C-section I was sure to have. It was my fault because I had gained 70 lbs. during pregnancy, and my body couldn’t even do the ONE thing it was actually designed to do.” Fiona (BS44) expressed guilt, writing: “But the guilt of the C-section was still lingering… did the doctor give up on me too quickly? Did he just think that I was just fat and lazy?” Carina (BS36) expressed, “I blamed my bigger body and my weight for years. Next time would be different.”

Social Bias and Stigmatization

Several women discussed perceptions of social bias and stigmatization. For example, Cara (BS3) wrote, “Often plus-size moms are given disapproving glances, and can be treated unfairly.” Helen (BS8) described, *“*Google and many medical providers (and a lot of keyboard warriors on the Internet) will absolutely terrify and shame you when you’re plus-sized and pregnant.” Brianna (BS27), who chose to be a surrogate mother, shared:

> I was still met with incredible negativity from other surrogates who believed I should not have been approved [for surrogacy]. Many insisted I could not possibly be healthy if I had a BMI. I even had one surrogate tell me my choice to do this meant that if I got pregnant, I would probably just 'kill their baby because you're too fat.' It got to the point where I never mentioned anything about my weight or posted full-baby pictures for fear of getting attacked.

Struggles with PCOS

Some plus-size women described their struggles with being overweight were attributed to their past experiences with PCOS. Cara (BS3) recorded, "My weight gain started when I turned 16, due to PCOS, and I've worked hard since then to try to be healthier, but some people don't ask… they just judge." Georgia (BS7) stated, "I was first diagnosed at the age of 11 with polycystic ovarian syndrome in the year 2000. I was overweight, and none of the attempts to lose weight were helping."

In addition to weight gain, some women discussed their concerns about infertility. For example, Zenoba (BS31) wrote:

> I was diagnosed with PCOS when I was 18. The afternoon after my diagnosis, I cried on my way to work because the first thing I saw when I googled PCOS was INFERTILITY. I always wanted to be a mommy, and all I had were the heartbreaking search results that told me it would be a gift I might never receive.

Ann (BS33) noted:

> When I was 17, I was diagnosed with PCOS and told that I would be unlikely to have children because of it and my size. I always wanted to be a mother. It was my biggest dream. Even knowing it was unlikely, it was still my biggest dream, what I wanted the most out of life.

Weight Loss Motivation and Struggles for a Healthy Pregnancy

Some women shared past histories of being overweight and their struggles with weight loss, describing their commitments to become active, eat healthily, and lose weight to enhance their ability to conceive and reduce pregnancy risks due to obesity. Enid (BS5) wrote about her effort to lose weight to be healthy and increase her chances of conception:

> At my highest weight, I was almost 400 lbs. I finally found a good place where I was active and eating healthy by still enjoying myself. These changes put me around 300 lbs. – 310 lbs. I was happy with this, so my husband and I started trying to conceive.

Tonya (BS23) recorded her depression and anxiety along with failures of intrauterine insemination (IUI), a type of artificial insemination procedure for treating infertility, in vitro fertilization (IVF), and pressure to lose more weight:

> After five failed rounds of IUIs, we were set to start our first IVF round. Sadly, I continued to struggle with depression and anxiety, feeling this would never happen for us or I wasn't destined to be a mother. I was again told to lose more weight (the fertility drugs are so mean as they make you gain weight during their treatments). I worked so hard to lose the remaining amount of weight.

Theme 2: Participation in Decision-Making

Plus-size pregnant women described their desires for birth, being involved in shared decision-making regarding their pregnancy and childbirth, and having a healthy baby. These desires fall within the Clandinin and Connelly's (2000) description of personal conditions concerning the "feelings, hopes and desires" (p. 480) expressed in the blogger's writings. Some bloggers had preferences for their birth settings, such as home birth, a birthing center, or a hospital.

Birth Plan

Plus-size pregnant women shared their desires for labor, birth, and care of themselves and their newborns. Nineteen women posted about their birth plans. Many women desired natural childbirth without epidural or other major interventions. Their birth planning experiences were influenced by a personal desire for skin-to-skin bonding with a baby, preference not to have invasive or pharmacological interventions, past experiences of cesarean delivery, or social interactions with other women and healthcare providers. For example, Kathryn (BS12) described her best and worst scenarios of birth plans and worried about missing skin-to-skin bonding with her baby during a cesarean delivery; as she wrote:

> The worst-case scenario was a plus-size emergency C-section with a general anesthetic. This would result in me missing the 'golden hour' of skin on skin bonding with my baby. The best-case scenario was a natural birth with no drugs and minimal interventions.

Laura (BS13) was open to any intervention but wanted a natural birth without an invasive intervention: "We had a birth plan…to go as natural as reasonable, but be open to interventions if necessary. No IV, no intermittent external monitoring, no epidural, no Pitocin, no cesarean."

Mary (BS14) also wanted a vaginal birth without a significant intervention:

> That's why I wrote out a detailed birth plan, [I] wanted to try for a vaginal delivery with no epidural or major interventions. I never liked the idea of being confined to the bed. I have been afraid of needles all my life and had an inkling that I might not want to push while lying on my back.

A couple of women, who had previously had a cesarean delivery, did a trial of labor after cesarean to achieve their goal of having a VBAC. Patricia (BS17) documented:

> I knew I wanted to try a vaginal delivery with my next baby. My C-section was fine, and everything went as planned, but it's not what I wanted. I wanted a vaginal birth… We

talked about having a vaginal birth after cesarean throughout my second pregnancy, and it was the plan to go that route.

Carina (BS36) wanted a vaginal birth to prove that her plus-sized body was capable of it:

I yearned for a VBAC and know that my size 24 body is capable of birthing. I can't even tell you why. It is just something I wanted so badly, to prove to myself that my plus-sized body is capable and not broken.

Quinn (BS18) wanted a water birth in a birth center but accepted the transfer to a hospital when experiencing labor dystocia to receive an epidural and medical augmentation of labor:

I wanted a water birth. I wanted it to be intimate, and I wanted to be more connected this time around. From my birthing center experience to the hospital, I was lucky to have had the care I did. I may not have given birth in the exact place I wanted. However, I still got to experience something many women never do, 44 hours of unmedicated labor.

Dianna (BS37) described her decision of birth plan and long efforts to search for the best birth and midwife assistance by writing:

It was very important for me to spend adequate time researching and finding what would be best for my baby and me on her birthday. This was a big deal, and as much time as I spent planning our wedding, I figured this deserved as much if not greater respect. I decided on natural birth, assisted by a midwife, in a birthing unit located within a hospital.

Helen (BS8) described her birth plan experience and support from a doula:

I'm currently expecting our second baby, due in just a few weeks. So I'll come to this birth with another birth plan… our doula has graciously worked with us so that she can be with us for this birth… And we're gonna do the best we can. That's all we can do.

> And at the end of the day, I will trust my care providers to do everything they need to keep me and my baby safe… the thing that has me feeling a little more at peace with this next birth is letting go of the idea that everything has to be perfect.

As part of the birth plans, where the birth would occur was also important to some plus-size bloggers. Clandinin (2013) refers to the situational commonplace as the "specific, concrete, physical and topological boundaries of place" (p. 40), recognizing the mutual connection between the situational (place) boundaries and experience. Three women expressed their desires for a home birth within the blogs, which each woman accomplished. Helen (BS8) wrote: "I was informed that I was neither a candidate for home birth nor for the local birth center." However, Helen did not tie any emotion to the provided facts. Olivia (BS16) desired to have her birth in a birthing center but understood: "should anything go wrong, or if you requested pain medication aside from nitrous oxide, they'd quickly transport you to the hospital across the street." Olivia (BS16) was thrilled when she was able to stay in the birth center for her delivery, writing: "I could have my baby at the center the way I had planned! No hospital, no interventions! I could officially add overjoyed to the running list of emotions I was feeling."

Involve Me in Decision-Making Related to My Plan of Care

It was important for plus-size women to remain autonomous in decision-making after being informed about alternatives if labor and birth did not proceed as planned. For example, Olivia (BS16) described a conversation with her midwife as educational and appreciated options provided for her decision, writing:

> When I reached 40 weeks (my midwife and I) did have a conversation about induction, only this conversation was to educate me, and I was an active participant. I could choose to be induced at any time now that I had reached 40 weeks, but I could also choose to wait.

Xavia (BS28) also described the importance of informed decision-making throughout her experiences with her midwife:

> It's amazing to have continuity of care and informed decision-making. Things are presented as options. I chose to get the gestational diabetes test done, but it was never mandatory. I chose to have the GBS [Group B Strep] swab done, but it was never mandatory. I also could do the swab myself at the office, which was better. … I saw an OB/GYN for a consult at about 30 weeks. My choice was whether I wanted to, and my midwife presented it as an option due to my past blood pressure issues. She thought it might be good to have some guidelines if it creeps up again.

Putting the Best Interests of My Baby First

Some women wrote that despite birth plans changing, in the end, all that mattered was a healthy baby. Irene (BS9) described her birth as traumatic, noting that having a baby was the most important thing: "[My baby's] birth was traumatic, it was hard, it was disappointing, it was terrifying, it was long, it was awful. But the end result was a beautiful baby boy….and in the end, that was all that mattered." Despite her birth plan not being achieved due to a cesarean delivery, Kathryn (BS12) advised other plus-size pregnant women to:

> Trust yourself, your mom's gut, and your body. But also trust the medical team looking after you. It's a balance between Mother Nature and science, but it can be done right. At the end of the day, the BEST outcome is to have your baby safely in your arms, regardless of how she got there…So we went from natural intervention-free hospital birth to a rushed cesarean with a general anesthetic. It's good to stick to your birth plans, but it's also good to listen to Mother Nature's cues. Be prepared to change your outlook for the best interests of your baby.

Theme 3: Empowerment

Pregnancy Motivates

Some woman viewed their pregnancy as a motivation to adopt a healthier lifestyle. Laura (BS13) stated:

> I would do what was needed to have as natural a childbirth as possible, but be open to whatever was needed to keep my baby and me safe and healthy. That meant a good diet, continuing my 2-3 days per week habit at Curves, and getting the education I needed to have a healthy pregnancy, natural birth, and successful breastfeeding journey.

Oliva (BS16) also wrote, "I absolutely LOVED being pregnant! I was motivated to eat well and exercise regularly, and I felt amazing! The first flutters turned to kicks and rolls, and the feeling of life inside my body was indescribable."

Empowerment by Other Plus-Size Women's Blogs

Some women felt empowered after reading other bloggers' birth stories on the Plus-Size Birth website. For example, Helen (BS8) wrote:

> I recently read another mom's birth story on the Plus Mommy blog, and she makes the point that there are many things you ultimately can't choose about how your birth will go. Birth plans are a marvelous tool…I'm not saying you shouldn't prepare yourself in whatever ways you can or want to. We had the most beautiful pregnancy and birth…Back to my original point, the thing that has me feeling a little more at peace with this next birth is letting go of the idea that everything must be perfect.

Tonya (BS23) wrote: "I explored the Plus-Size Birth blog and read other women's stories. I became so empowered that I decided my birth was going to be the way I wanted, not the OB's." Zenoba (BS31) noted:

> That's the time I discovered Plus-Size Birth. I read your story and the stories of other plus-size mamas who were in control of their bodies and had the birth and pregnancies they wanted, not what was convenient for the doctor. It empowered me to start standing up for myself with my care and research things before taking what I was told at face value.

Dianna (BS37) described how reading other plus-size birth stories helped comfort her during her plus-size pregnancy: "I am sharing my story because I found great comfort in reading the memoirs of other mommies who had delivered naturally, especially women considered plus-size. I had several obstacles to overcome but could deliver my healthy daughter completely naturally."

Reassurance, Support, and Encouragement by Healthcare Providers

Some women shared experiences with size-friendly healthcare providers who offered reassurance, support, and encouragement throughout their plus-size pregnancy and birth. For example, Brittany (BS2) wrote: "From the time I started going to the birth center, they (the birth center team) encouraged me and told me that I could have the birth I wanted." Cara (BS3) wrote, "My doctors calmed me many times and were so body positive that I thought I would get the vaginal delivery I planned for." Georgia (BS7) described her healthcare provider's acceptance of her desired birth: "I explained to my doctor there that I wanted to have a natural, 100% water birth, with no medications, and he explained to me that he would do what he could to support my decision."

Some women expressed appreciation for their healthcare providers and team members for their support and encouragement. For example, Tonya (BS23) wrote: "My midwife listened to every question I had and validated every desire I had for my birth, encouraging me the whole way. It was a match made in heaven." Helen (BS8) noted, "My whole birth team was so positive

and encouraging. I never did end up getting meds." Jenna (BS10) described an anesthesiologist's support during her cesarean delivery as follows: "At one point during the surgery, the anesthesiologist leaned down in my ear and said…you are a champion."

Theme 4: Respectful Care Is Appreciated

Some women shared experiences with insensitive healthcare providers who were not size-friendly, appeared judgmental, and demonstrated bias and stigmatizing behaviors. With these interactions, women perceived less than respectful care. Other women shared experiences where their provider seemed to look past their weight and treated them with dignity and respect.

Don't Treat Me Different Because I'm Plus-Size

Women described experiences of healthcare providers refusing to care for plus-size women, healthcare providers' assumptions of risk, and limited labor options and resources for plus-size women. These social experiences were placed with feelings of being mistreated, judged, and shamed for being plus-size and pregnant in birth stories posted by plus-sized pregnant women. For example, Alice (BS1) wrote her experience of unwanted procedures done by an insistent anesthesia provider during her labor:

> Unfortunately, the anesthesiologist had to come and talk to me about getting an IV (intravenous access) and all this other crap because of my weight. I flatly refused, and they pretty much told me that it was hospital policy to have at least a hep-lock with somebody of my size. That really pissed me off, and I finally said whatever just to get it done.

Enid (BS5) felt that she did not get enough assistance from her lactation consultant due to her size: "My lactation consultant wasn't very size-friendly. Breastfeeding didn't work after a few weeks." Wanda (BS27) had difficulty finding a fertility doctor, writing: "Many reproductive endocrinologists (RE) have a body mass index (BMI) restriction, most of which are under 30."

Victoria (BS25) described her obstetrician's refusal to manage her pregnancy: "When I finally reached my 8-week mark and went to my OB/GYN, he refused to continue to see me stating their 'practice rule' was to not deliver a woman with a BMI over 40. My BMI was 42."

Several women discussed healthcare providers' assumptions of complications related to the pregnancy. Mary (BS14) was scared with a midwife's explanation of possible complications and needed to accept her categorized as "high-risk" with relevant tests despite no complications in her pregnancy:

> When we asked what about my pregnancy was considered 'high-risk,' the midwife explained that it was hospital policy for me to undergo the scans because of my higher BMI. She explained scary terms like 'spontaneous fetal death, increased risk of birth defects and emergency cesarean.' She said I could refuse the non-stress tests if I wanted to but made it sound like I was putting myself and my baby at risk if I did.

Olivia (BS16) pointed out the word choice of "would" compared to "could" and "might" to have complications in a conversation for her healthcare provider:

> As she listened for the heartbeat, she said, 'now you know we're asking you not to gain any weight.' I just shrugged it off. Then we talked about an early gestational diabetes test. I was told 'when' – not if – they got the results that I 'would' – not could, not might – be diagnosed and sent to a nutritionist. I fully admit that that appointment ruffled my feathers.

Tonya (BS23) shared her feeling of discouragement from hearing her healthcare provider's plan for potential complications:

> "I was instructed to plan on having gestational diabetes and hypertension because of my size. I was shocked that our happiness of a healthy baby was deflated with how my body

would fail us again. And to make matters worse, I was told that a C-section would most likely be the way our birth would go."

Some women described feeling mistreated by other healthcare professionals. Zenoba (BS25) wrote: "I am an active and healthy woman who just happens to be obese. I felt extremely judged by the doctors and other staff members. I have never felt more mistreated in my life." Fiona (BS44) shared an anesthesia provider's dissatisfied remarks about her body size*:*

> A few hours later, the anesthesiologist walked in. He complained about my weight and how hard it will be to put the spinal block in, 'Can you even sit Indian Style?' Well, I may be big, but I am certainly not too big to sit cross-legged. He was totally shocked that I was able to do this! The whole time he was looking at my back, he commented how big I was.

Fionna (BS44) also described feeling mistreated by a nurse at her clinic visits: Nurses have always been the people I respected the most. My mother is a nurse, and I've seen her handle people in many situations. She was NEVER judgmental or cruel. What could possibly be so wrong about me that this nurse felt she had to make me feel like I was some kind of monster?

Less Emphasis on My Plus-Size

Some women wrote about positive feelings from experiences with their healthcare providers. Their weight was considered problematic or shifting focus away from the plus-size woman's weight. For example, Nina (BS15) wrote: "I was assigned to a high-risk doctor. My new doctor didn't find my weight as an issue. It was never brought up." Olivia (BS16) was relieved after her first appointment:

> I asked my doctor if my weight was a problem. Should I watch what I gained, be concerned about anything, or cut anything out of my diet? He practically laughed it off

and told me only to avoid caffeine if I could and cut out artificial sweeteners. I left that appointment feeling great – like I'd had a huge weight lifted off my shoulders.

Susan (BS22) described:

> The nurses and midwives would check my blood pressure, listen to the baby, and feel my belly. The first question at every appointment was, 'how do you feel?' They never mentioned my weight because everything else looked and sounded perfect.

Jenna (BS10) described receiving respectful care from her OB/GYN provider by stating: "(my doctor) treated me with love, dignity, and care and NEVER made me feel like I couldn't do something because I was overweight." Kathryn (BS12) commented: "I was blessed with an amazing OB who never once mentioned my size, never once commented on my body apart from the actual pregnancy, and who was fully supportive of my dreams for an unmedicated vaginal birth."

Finding the Healthcare Provider and Support I Deserve

Some plus-sized pregnant women advocated for themselves and switched maternity care to a more supportive care environment. These women described their choice to leave healthcare providers when perceiving bias, stigmatization, and judgment. For example, Donna (BS4) wrote: "When my OB/GYN provider suggested that I should be open to the possibility of induced labor or a C-section, both of which are standard interventions in our area, (my husband) and I decided to make a change." Helen (BS8) felt empowered to switch to midwifery care upon discovering that her physician was not size-friendly:

> They started scheduling me for non-stress tests when I hit my third trimester. No one would explain to me why this was. So at thirty weeks (which is a little late), we officially transferred to the midwives. You think you start your pregnancy with a size-friendly provider, but then as things progress, you start to realize that maybe they're not.

Victoria (BS25) described her joy of making the decision to switch providers:

> I happened to call the office of (my new doctor). I believe I went through a terrible experience with my physician to have a truly amazing experience with (my new doctor). He is kind, full-figure friendly, and smart. He never once made me feel judged or less than a human-like my original OB/GYN. He made my experience exactly what we had imagined. He made my husband and I feel 'normal.' The sensitive subjects that must be discussed when you're obese and pregnant, he approached tactfully and caring.

Zenoba (BS31) also described finding a better fit when switching providers, writing:

> I begged to be transferred to the Midwifery program, and I'm so glad I advocated for myself. Not only did they quit asking me about gestational diabetes, they actually started EDUCATING me about my pregnancy. …I started showing and making the very most of my 'B' belly, and we were so happy with the way our care was going.

In the blogs, some women chose to end their story with advice to empower other plus-size women to advocate for themselves and obtain the healthcare providers they deserve. For example, Cara (BS3) wrote: "You also deserve a team of doctors and nurses that will support you and lift you up during your pregnancy." Georgia (BS7) wrote:

> Don't let a doctor make you feel like you're worthless and nothing. They work for you. Not the other way around. If they treat you like you know nothing, throw research in their face and demand care. They are the ones who took the Hippocratic Oath, saying do no harm. Remember, just because you're plus-size doesn't mean you deserve to be treated anything less than you deserve. You deserve all the respect and love in this world, and you have earned that.

Olivia (BS16) wrote: “It’s my hope all women – plus-size or otherwise – feel empowered enough to know that they have rights and options when it comes to their care. If they aren’t completely happy and comfortable with something – change it.” Quinn (BS18) wrote:

> The moral of my story, as a plus-size mom, is that you get to take your care into your own hands. Don’t settle for a doctor who makes you feel like you’re less. Don’t settle at all. Find doctors/midwives who make you feel safe.

Victoria (BS25) advocated size-friendly providers for plus-size women:

> Women need to know that there are size-friendly providers out there. Just because we are plus-sized and pregnant does not mean we should settle for a physician that makes us feel less than human because of a number on a scale. My hope is that every plus-size pregnant woman gets to feel confident with their provider.”

Theme 5: Celebrating the Success of the Plus-Size Woman:

Some plus-size women described that they could celebrate their pregnancy and birth by debunking plus-size pregnancy assumptions and finding a new appreciation and trust in the capabilities of their plus-size body in the end.

Debunking Plus-Size Pregnancy Myths

Several women celebrated passing their glucose screens and not developing gestational diabetes. Laura (BS13) felt lucky when she passed her glucose screens:

> I already ate low carb, high protein. Add the Brewer diet instructions from our Bradley class and a trip to Curves 2-3 times a week, and I had the best chance to avoid GD (gestational diabetes). Luckily, I passed glucose challenge tests with flying colors.

Nina (BS15) shared a similar experience: “I was tested early at 16 weeks for gestational diabetes and again at 26 weeks due to my BMI. Luckily I never got it.”

In addition to passing glucose screens, other women celebrated maintaining normal blood pressure during pregnancy without developing preeclampsia. Helen (BS8) wrote: "(I) maintained excellent blood pressure and aced my glucose screening." Tonya (BS23) wrote: "I tested negative for gestational diabetes, and my blood pressures were absolutely normal."

Some women expressed relief from successful procedures and births despite their weight. Nina (BS15) wrote: "My epidural went in on the first try and worked wonders. I was so happy as I read that being overweight could interfere with the placement." Patricia (BS17) discussed doubting her body's ability to have a vaginal birth after having a cesarean delivery with a prior pregnancy. However, after laboring and achieving a vaginal delivery, she is surprised that she doubted her body's abilities:

> Thinking back at those amazingly hard 30 hours and how emotional they were, I can't believe I doubted my body and my baby. I have two wonderfully healthy girls, one born by C-section and one vaginally. I'm so thankful that both of my experiences went well.

Some women celebrated that their weight did not impact their pregnancy and birth. Rosemary (BS21) expressed joy that her body was capable of birthing as she wrote:

> My body began to push on its own. That was one of the most amazing feelings of my life. My body did know what to do and was doing it! It felt amazing. I did it. My body did not fail.

Fiona (BS44) highlighted that her cesarean delivery was not a result of her weight: "My son had the cord wrapped twice around his neck, which would explain the REAL reason for a C-section, there was no way for him to descend into my pelvis. It had nothing to do with my weight."

When learning about congenital defects, a couple of women expressed relief that their weight was not a factor. Fran (BS6) found out that her daughter would be born with one hand: "I

asked the doctor if my size played a factor in what happened to her, and he assured me that my size had nothing to do with it." Helen (BS8) expressed relief that her son's heart defect was not a result of her plus-size pregnancy:

> We recently found out that my son has a genetic disorder that is likely the cause of his heart defects. This is something that could have happened regardless of my size. In general, I have met heart mamas of all sizes and backgrounds.

Trusting and Loving My Body

The Clandinin and Connelly (2000) notion of temporality as the past, present, and future suggests that experiences have a past, a present, and an implied future. It was noted in the narratives that women's experiences with pregnancy and childbirth impacted the way they respected their bodies and their body's capabilities of achieving pregnancy and birth. Jenna (BS10) wrote: "I am so proud of this plus-size, pregnant body. This body that I'd hated for 32 years was all of a sudden a freakin' HUMAN MAKER. What better superpower is there in this life?" Mary (BS14) described appreciation for her plus-size body:

> I'm so proud of myself for getting the birth experience I wanted. I definitely know that I will never be down on myself about my body again. My body is a masterpiece after what it did to get my son here safely.

Patricia (BS16) wrote: "Overall, my weight did not play any type of role during my pregnancy. I realized what a powerhouse I was and that my body knew what it needed to do, even though it was a little bigger than most." Dianna (BS37) appreciated her body's abilities: "Taking charge of my birth and actively participating in it gave my daughter and me a gift that I truly consider invaluable. I have never felt so empowered and impressed with my body's abilities."

Plus-size pregnant women advised each other in the blogged site to love and trust their own bodies. Cara (BS3) wrote: “Love yourself and love your body. Mine gave me my daughter, and she makes all the pain worth it.” Brianna (BS34) also wrote: “I want plus-size women to realize that your size doesn’t determine how your pregnancy will go. So stay positive and keep your head up.” Dianna (BS37) also encouraged other plus-size pregnant women: “You CAN do it. Our bodies were made for this. Trust in yourself, and you can do anything.”

Chapter Summary

This chapter presented the findings from the narrative inquiry analysis of a total of 32 birth stories blogged on the Plus-Size Birth website. This study found that maternity and childbirth experiences of obese or plus-size women were impacted through various interactions within the three-dimensional space of social, temporal, and situational commonplaces described by Clandinin and Connelly (2000). Five major themes with 15 sub-themes regarding their maternity and birth experiences were derived from the narrative analysis.

The first major theme was Struggles and Negative Feelings. This theme relates to both the temporality commonplace related to women’s past experiences brought forth to their plus-size pregnancy and childbirth experiences and the sociality commonplace in which the women described their personal conditions related to their feelings. This theme embraces plus-size women’s postings about their self-blame, fear, and guilt related to their pregnancy, perceptions of social bias and stigmatization, struggles with PCOS, their attempts at weight loss, and struggles for a healthy pregnancy.

The second theme was Participation in Decision-Making, which represented diverse personal conditions (e.g., feelings, hopes, and desires). Plus-size pregnant women described their

desires for birth, being involved in shared decision-making regarding their pregnancy and childbirth, having a healthy baby, and preferences for their birth settings.

The third theme was Empowerment*,* representing plus-size women's motivation to adopt a healthier lifestyle change, feeling empowered by reading blogs of birth stories from other plus-size women. Women also felt empowered by receiving reassurance, support, and encouragement from their healthcare providers.

The fourth theme, Respectful Care Is Appreciated, represents the experiences of being treated with less respect because of their plus-size, judged, and shamed. However, other women appreciated receiving respectful and dignified care from providers who placed less emphasis on their plus-size or made it appear that their weight was not problematic. Clandinin (2013) emphasized that social interactions deeply impact events in a person's life. Some plus-size women left healthcare providers who offered less respectful care to find other healthcare providers who would give them the support they deserved. The women used their birth stories to provide advice, support, and encouragement to advocate for themselves.

The fifth theme was Celebrating the Success of the Plus-Size Women, in which plus-size women celebrated their pregnancies, their birth, and their bodies in the process of achieving birth. They celebrated that the risks of obesity in pregnancy did not impact them. Furthermore, plus-size women celebrated gaining a new trusting and loving relationship with their bodies as a result of their pregnancy and childbirth experience.

CHAPTER V

DISCUSSION

Introduction

This chapter presents discussions on the themes that emerged from this study along with the narrative inquiry framework. The chapter concludes with the implications and recommendations for maternal healthcare practice, education, and research.

Discussion of the Findings

Theme 1: Struggles and Negative Feelings

The first major theme, Struggles and Negative Feelings, includes the four subthemes: (a) self-blame, fears, and guilt related to a plus-size pregnancy; (b) social bias and stigmatization; (c) struggles with polycystic ovarian syndrome and the attributed weight gain; and (d) weight-loss motivation and struggles for achieving a healthy pregnancy.

Concerns among plus-size women about how they are judged by healthcare providers are common as bias and stigmatization of plus-size women are evident in the literature. Common sources of weight stigmatization include society, media, strangers, family, and healthcare providers (Incollingo Rodriguez et al., 2020). Obese women who had experienced social bias and stigmatization from healthcare providers often felt blamed and even blamed themselves for potentially putting their pregnancy at risk due to obesity (Relph et al., 2021). Pregnant women who are obese face similar experiences of weight bias and stigmatization, reporting feelings of judgment, guilt, and shame during healthcare visits (Incollingo Rodriguez et al., 2020). Pregnant women with obesity often fear weight-related bias and discrimination when establishing prenatal care (Hurst et al., 2021). Further, women with obesity suffered psychological and emotional effects, which influenced their perception of quality care based on their interactions with

providers during pregnancy (Bernecki DeJoy et al., 2016). Individuals who experience weight bias in healthcare report "contemptuous, patronizing and disrespectful treatment" (Alberga et al., 2019, p. 9).

In this study, 19 women discussed their struggles and negative feelings related to PCOS and attributed their plus-size to PCOS. PCOS has been cited as the most common cause of female infertility, affecting 6% to 12% of women in the United States of childbearing age (CDC, 2020). Vora and Patil (2015) found that weight was a concern among women with PCOS, and these women had trouble managing their weight and experienced frustration in their attempts to lose weight. In addition, these women felt sadness about problems with infertility. They felt out of control with their ability to have children.

This study found that women with PCOS posted distrust of their primary healthcare providers on their blogs with feelings that their healthcare providers are less qualified to treat PCOS concerns. Lin et al. (2018) found similar perceptions from their subjects and speculated that this might be due to a lack of specialty in endocrinology among OB/GYN physicians. Careful listening to their PCOS concerns and relevant struggles and providing support and encouragement are essential to improve patient-provider relationships in women with PCOS. More research is needed to identify areas to improve the patient-provider relationship and trust.

Some blogged stories in this study showed that some women recalled their past weight loss struggles and discussed feeling motivated to adopt a healthy lifestyle to have a healthy pregnancy and newborn. Pregnancy can be a powerful motivator for making healthy changes, particularly in food choices (Grenier et al., 2021; Lindqvist et al., 2017; O'Brien et al., 2017; Phelan, 2010). Healthy food choices and appropriate physical activity during pregnancy are beneficial for maternal and fetal outcomes (ACOG, 2020; DiPietro et al., 2019, Faucher et al.,

2021). Many obese women report a long history of dieting and managing their weight (Cunningham et al., 2018). Plus-size women often desire advice from their care providers about managing their weight, including healthy, appropriate exercise, and appropriate weight gain during pregnancy (Faucher et al., 2021; Holton et al., 2017; Nikolopoulos et al., 2017). Many women who reported a lack of dietary and physical activity advice indicated that their provider's direction would help them follow healthier behaviors during pregnancy (Cunningham et al., 2018; Weeks et al., 2020). Healthcare providers must be knowledgeable about appropriate gestational weight gain consistent with guidelines identified by the CDC (2021), which specifies recommended weight gain based on prepregnancy body mass. The recommendation is that obese women gain 11-20 pounds versus the recommended weight gain of 25-35 pounds for women who fall within a normal weight range.

Gestational weight gain can be managed with healthy lifestyle choices such as healthy eating and physical activity during pregnancy (Mijatovic-Vukas et al., 2018). The ACOG (2020) recommended safe exercise during pregnancy, such as walking, stretching, and water aerobics. ACOG further stated that the benefits of exercise have been shown to lower the incidence of excessive gestational weight gain, gestational diabetes mellitus, gestational hypertensive disorders, and cesarean section. However, as pregnant women with obesity are overly concerned with nutrition and activity (Thorbjornsdottier et al., 2020), careful interaction is required. Healthcare providers caring for pregnant women can benefit from specific training in discussing weight management during pregnancy (Holton et al., 2017). Sensitivity training allows providers to gain a level of comfort and confidence when approaching plus-size women to provide education on healthy dietary choices, physical activity, and avoidance of excessive gestational weight gain (Poston, 2017). In addition, healthcare providers should allow women to have the

tools to self-manage their healthy lifestyle activities, taking into account their preferences (Dencker et al., 2016). Suggestions can include helping women to make healthy dietary choices and how these can help their health and the baby's health throughout pregnancy and beyond by introducing evidence-based facts about diet, pregnancy, and physical activity.

Education about obesity facts training in person-centered communication, (i.e., motivational interviewing) as well as access to dieticians may facilitate gestational weight management (Carlson et al., 2018; Christenson et al., 2020). Motivational interviewing, introduced by William Miller in 1983, explores ambivalence towards their current health behavior in favor of a change. Motivational interviewing involves the following overlapping processes: 1) engaging in a working relationship; 2) focusing on a problem to change; 3) evoking the person's desire to change; and 4) planning the change (Miller & Rose, 2009). Motivational interviewing has been acknowledged as a potential method to enhance communication with overweight or obese pregnant women and improve overall outcomes (Dieterich & Demirci, 2020). Healthcare providers need to communicate the importance of limiting gestational weight gain and discussing strategies that are agreeable to the woman, using a sensitive and non-judgmental approach.

Theme 2: Participation in Decision-Making

The second major theme, Participation in Decision-Making, was derived from plus-size women's postings about birth plans and their desire to be involved in healthcare decision-making throughout pregnancy and childbirth, especially when the birth did not go as planned. Birth plans were first introduced in the 1980s as a tool to communicate their birthing preferences and desire for care during childbirth to their caregivers (Lothian, 2006). Birth plans provide opportunities to open discussion between pregnant women and their healthcare providers about their birth

preferences and desire for care; and present an opportunity for women to express their concerns and any misperceptions (Anderson et al., 2017; Divall et al., 2017). The World Health Organization (2018) recommends using birth plans to improve shared decision-making between women and healthcare providers during pregnancy and birth. Studies have indicated women with birth plans have fewer obstetrical interventions (Afshar et al., 2017; Coates et al., 2020). Birth plans may even improve women's willingness to accept medically-indicated interventions, including cesarean section if necessary (Coates et al., 2020). Healthcare providers play an essential role in women's success in writing and using a birth plan (Divall et al., 2017).

Some plus-size pregnant women in this study posted on the blog site that they could participate in shared decision-making and discussed the importance and overall satisfaction of being involved in the decisions for their care. In contrast, other plus-size pregnant women reported more negative feelings toward paternalistic views of their healthcare providers and assumptions of complications during childbirth. Healthcare providers should integrate shared decision-making and practice into all women's maternity and childbirth care (Megregian et al., 2020). However, research findings have indicated that even established standards for shared decision-making are not reliably implemented in maternity care (Declercq et al., 2018). It is evident in the literature that the purpose of birth plans as a means to facilitate shared decision-making is still not fully recognized among healthcare providers (Jolles et al., 2019). More research is needed to determine implementation strategies to increase birth plan use for every woman. Shared decision-making and respect for the plus-size woman and her autonomy are vital to supporting her and promoting a positive childbirth experience (Thorbjornsdottier et al., 2020). Healthcare providers should focus on obese pregnant women's unique needs and expectations while allowing them to choose and control their care (Davison, 2021).

Theme 3: Empowerment

The third major theme, Empowerment, embraces plus-size pregnant women's perceptions towards pregnancy to themselves, their empowerment affected by reading childbirth stories from other plus-size pregnant women, and their experiences of reassurance, support, and encouragement by healthcare providers. Pregnancy can be a powerful motivator for making healthy changes, particularly in food choices (Grenier et al., 2021; Lindqvist et al., 2017; O'Brien et al., 2017). Women can feel a strong sense of self-determination when advocating healthy lifestyle changes to ensure a healthy pregnancy.

Motivations for sharing birth stories can normalize different birth experiences and empower other women (Johnson et al., 2020). Social networking sites have played an empowering role in providing women with information and support through pregnancy and childbirth (Hallam et al., 2019). Forums and blogs have been a great way to bring together support groups (Calvillo et al., 2015). Healthcare providers can recommend their clients (obese pregnant women) to explore social media to interact with other obese pregnant women and support each other. Using blogs may provide an excellent opportunity to share information and establish a support group. Also, researchers can create a social media platform for obese pregnant women to provide information, facilitate peer support, collect data, and measure the effectiveness of the use of social media in the future.

Theme 4: Respectful Care Is Appreciated

This fourth major theme addresses the experiences of plus-size women who described being treated differently during pregnancy due to their plus size. In addition, several women desired maternity care that placed less emphasis on their weight and plus-size bodies and sought size-friendly and supportive healthcare providers. These perceptions of plus-size women can be

connected with their perceptions of healthcare providers' stigmatizing bias and judgmental behavior presented under the first major theme. This theme adds evidence to the previous study findings that plus-size women want to be treated with respect and a non-judgmental attitude (Christenson et al., 2020) and desire emotional support and sensitive healthcare providers as part of respectful maternity care (Downe et al., 2018). Steps to help reduce bias in healthcare may include informing healthcare providers about experiences and perceptions of plus-size women (Hurst et al., 2021), training and education about non-stigmatizing, respectful approaches when discussing weight with plus-size women and risk factors in pregnancy (Incollingo Rodriguez et al., 2020).

In this study, plus-size women appreciated it when their weight was not overly focused upon or even brought up as an issue. A previous study found a similar finding that women wished to avoid due to the anguish often caused when weighing (Knight-Agarwal et al., 2016). Women reported feeling worthless if they could not stick to an acceptable weight gain (Lingetun et al., 2017). Women with obesity during pregnancy experienced positivity and a sense of relief when working with healthcare providers who had a weight-neutral approach (Cook et al., 2019).

Several studies have indicated that many women with obesity in pregnancy received an extreme focus on high-risk status and negative outcomes due to their weight (Incollingo Rodriguez et al., 2020). Consistent with those studies, this study also found that plus-size women discussed healthcare provider assumptions of complications related to the pregnancy. While some women acknowledged the importance of education on obesity-related risks in pregnancy, they also wanted their healthcare provider to focus on positive information while showing support and encouragement (Thorbjornsdottier et al., 2020). When healthcare providers focused on risk, plus-size women felt that it was not helpful. Despite the necessity to be informed about

weight-related risks, plus-size women preferred the information to be communicated in a respectful and supportive way, with positive support and encouragement (Thorbjornsdottier et al., 2020). When healthcare providers inordinately focus on potential negative outcomes, it is often counterproductive, raising maternal anxiety (Incollingo Rodriguez et al., 2020).

In this study, some women described their choice to leave their healthcare providers when their behaviors were viewed as stigmatizing, biased or judgmental. In a scoping review, Alberga et al. (2019) determined that weight bias contributed to the lack of patient engagement in the healthcare of patients with obesity. Alberga et al. (2019) found that plus-size patients shopped for doctors when they perceived different healthcare treatments, lacked trust, and had poor communication with their healthcare providers. In this study, plus-size women advocated for their pregnancy and birth by switching to more body-friendly healthcare providers. Women who felt positive, supportive, and collaborative communication with their healthcare providers described a more positive and fulfilling encounter with healthcare providers (Thorbjornsdottier et al., 2020). Therefore, more efforts are needed to end weight bias and stigmatization and more awareness of the causes and obesity stigma and the resulting harmful effects. The ACOG published a committee opinion in 2019 on ethical considerations for the care of patients with obesity. This opinion includes essential aspects of patient-centered care, including the relationship with the patient, demonstrating empathy, sensitivity, and support, while providing an environment that offers safe, compassionate care and a supportive clinical setting. Healthcare providers may benefit from ethical education to provide an inclusive, comfortable care environment for plus-size patients (Cook et al., 2019).

Theme 5: Celebrating the Success of the Plus-Size Woman:

The fifth theme, Celebrating the Success of the Plus-Size Woman, describes the plus-size woman's desire for reassurance, support, and encouragement throughout pregnancy and birth. Within this theme, women discussed working with supportive and encouraging healthcare providers who advocated for them. Women celebrated when they could avoid some of the risk-related complications. The literature review revealed risks for women associated with maternal obesity: gestational diabetes, gestational hypertension, preeclampsia, anxiety, depression, labor induction, longer labor duration, and cesarean birth (Carlson et al., 2018). While many of the women in this study did have similar complications, it is important to recognize that several women did not experience such complications. It has been estimated that 58.2% of women with obesity without early complicating factors experienced pregnancy without complications; this is in comparison to 72.7% of women of healthy weight and no complicating factors (Relph et al., 2021). In addition, many women had better outcomes with interventions supporting physiologic birth without using more high-risk interventions during labor. For example, obese women with spontaneous labor receiving only physiologic labor interventions had outcomes that were similar or better than obese women who had more high-technology interventions (Carlson et al., 2017)

In general, pregnant women suffer negative body images due to pregnancy changes (Office on Women's Health, 2018). Women who are obese before pregnancy may have a poor body image before pregnancy. A poor body image can contribute to additional obesity-related health problems such as low self-esteem and depression (Urbańska & vel Dziurawiec, 2019). During the postpartum period, body image disturbances may also suffer from the sociocultural pressure from partners, peers, and media for postpartum weight loss and the thin-ideal (Lovering et al., 2018). Therefore, a negative body image before pregnancy may be compounded by

pregnancy changes and weight gain. However, in this study, plus-size women described appreciation for their bodies and the capability of their bodies to achieve birth. McCloud and Barosso (2021) found that women could have negative feelings toward their bodies before pregnancy yet have positive feelings and a new appreciation of their bodies and functionality while pregnant. One study indicated that when plus-size women experience an empowering birth experience, they often gain a new appreciation for their bodies and their capabilities. They gain a positive new body image, "strong, proud, and confident," which is then carried forward in their lives (Thorbjornsdottier et al., 2020, p.7).

Limitations

This study used online blogs as a valuable data source to investigate maternity and childbirth experiences of women who identified as obese or plus-size women. This researcher understood the limitations of this study, such as recognizing that relying on self-reported birth stories without interaction with this researcher does not allow external validation to confirm the interpretations of the findings with the study subjects. To validate the results and interpretations of the data, this researcher used peer review through the data collection and data analysis.

Some blogs lacked content causing difficulty with interpretations of the narratives and had to be excluded from this study. In addition, blogs with password protection and/or copyright were excluded from this study, limiting data availability.

However, there were many benefits of using blogs for data collection as this study helped overcome difficulties with recruiting women who identify as obese or plus-size, which can be related to women's reluctance of being judged and perhaps sharing their birth stories created less vulnerability in the anonymous digital environment. By collecting data from blogs using a retrospective approach, the data was not influenced by this researcher.

The use of narrative inquiry offered a unique method to use birth stories to understand the experiences of women who self-identified as obese or plus-sized and was an effective method to uncover what was important to each blogger who shared their birth story from their own perspective. Blogged narratives effectively allowed this researcher to explore the lived experience and answer the study's research questions. In addition, the use of Clandinin and Connelly's (2000) theory of experience within the three dimensions of temporality, sociality, and situation gave this researcher an opportunity to identify modifiable factors that were influential to the blogger's maternity and childbirth experience.

Implications for Maternal Healthcare Practice, Education, and Research

Implications for Practice

This study has implications for practice and the provision of patient-centered care. Patient-centered care represents several important concepts: 1) empathy; 2) respect; 3) engagement; 4) communication; 5) shared decision-making; 6) holistic focus; and 7) individualized focus (Ekland et al., 2019).

Plus-size women need empathy and understanding from healthcare providers based on their past experiences and struggles with their weight and associated complications. When care is deemed to be uncompassionate or lacking empathy, damage occurs to the patient/provider relationship (Riess 2017). Healthcare providers need to understand and acknowledge their own personal biases and actively participate in training opportunities aimed at helping to reduce this bias. Healthcare providers must focus on ethical considerations when caring for pregnant women who are overweight or obese and ensure that their clinical practice is accommodating and inclusive. Plus-size women identified the need to be engaged with their healthcare provider to feel valued as a person and commitment from their provider to be supportive and available to the

woman throughout her maternity care needs and birth experience. Plus-size women during pregnancy need to feel empowered to have a more positive view of their birth experience.

Effective communication is required for patient-centered care. Healthcare providers' communication should be sensitive and respectful. Positive, therapeutic communication is important to let women know their risk factors, complications, and strategies to decrease their risks without hyper-focus on or assuming these risks. Healthcare providers may consider the need for sensitivity training for discussing weight and weight management during pregnancy to consistently provide accurate and evidence-based information through non-biased and non-judgmental communication. Training in motivational interviewing may help enhance communication.

Healthcare providers need to involve plus-size patients in their birth planning and encourage shared decision-making. By focusing on the woman's unique needs and expectations, the woman feels empowered to choose and control her care. Options for birth should not be based on weight only. If it is inevitable to change the birth plan, women should be informed about the rationale and alternative options. The woman should have the ability to choose options with informed consent for the safety of both the woman and the baby

Patient-centered care takes a holistic view of a patient's overall health (Sinaiko et al., 2019). The process of learning and understanding the patient is holistic, patient-centered care (Ekland et al., 2019). Holistic care sees the woman from a biopsychosocial perspective and acknowledges her whole life and self-beliefs (Ekland et al., 2019). Healthcare providers need to be aware of plus-size women's struggles and negative feelings to understand and know their patients. Understanding any struggles and negative feelings that may impact the plus-size woman's pregnancy and childbirth experiences is a good holistic care practice. Therefore,

healthcare providers should discuss and address plus-size women's social, emotional, physical, and psychological needs and expectations during pregnancy and childbirth. Also, healthcare providers should provide individualized care, recognizing each woman as a unique, holistic being. Healthcare providers must be knowledgeable about appropriate gestational weight gain consistent with CDC (2021) guidelines.

Implications for Education

Empathy training and sensitivity training related explicitly to the plus-size maternal patient should be placed in educational settings in order to nurture good healthcare providers (e.g., nurses, physicians, midwives, etc.) to offer support and encouragement without negative assumptions. Healthcare providers need to self-assess their possible biases (conscious or unconscious) and their consequences on verbal or non-verbal interactions with patients. Students and healthcare providers should learn best practices for providing sensitive care to obese pregnant women and maintain honest, factual, and open communication when discussing maternal obesity, free from bias and stigmatization. Motivational interview techniques could be integrated into a training module to enhance communication.

Implications for Research

Future studies are recommended to examine the effects of educational training (e.g., empathy training, motivational training, sensitivity training, etc.) on all healthcare providers' practice outcomes and patient outcomes, particularly with caring for the obese woman during pregnancy and childbirth. In addition, future studies should focus on methods to ensure equitable healthcare for women who are obese. More research is needed to identify what inclusive care looks like to the plus-size pregnant woman. Researchers can also create a social media platform

for obese pregnant women to provide information, facilitate peer support, collect data and measure the effectiveness of the use of social media in the future.

Chapter Summary

This chapter presented discussion on the themes emerged from this study using the narrative inquiry framework and identifying social, temporal, and situational factors that influenced the maternity and childbirth experiences as described in their blogged birth stories. This study provided valuable insight that might help guide healthcare providers in the provision of patient-centered care.

Implications for practice were discussed to include the description of elements in providing patient-centered care to obese women to include: 1) empathy; 2) respect; 3 engagement; 4) communication; 5) shared decision-making; 6) holistic focus; and 7) individualized care. These patient-centered care strategies are all aimed to improve patient/provider relationships, which can contribute to positive maternal and fetal outcomes. Implications for healthcare provider education include empathy training, sensitivity training, and motivational interviewing to enhance communication between the obese patient and the provider. Finally, implications for future research were discussed, including an examination of the effects of diverse educational training on all healthcare providers' practice outcomes and patient outcomes, particularly for the obese pregnant woman. Also, future research is recommended to create and explore social media platform to provide information, facilitate peer support, collect data and measure the effectiveness of the use of social media.

REFERENCES

Afshar, Y., Mei, J. Y., Gregory, K. D., Kilpatrick, S. J., & Esakoff, T. F. (2017). Birth plans – Impact on mode of delivery, obstetrical interventions, and birth experience satisfaction: A prospective cohort study. *Birth*, *45*(1), 43-49. https://doi.org/10.1111/birt.12320.

Agency for Healthcare Research and Quality. (2017, March). *What is patient experience?* https://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html

Agency for Healthcare Research and Quality. (2018, November). *Six domains of health care quality*. https://www.ahrq.gov/talkingquality/measures/six-domains.html#_ftn1

Agrawal, P. (2015). Maternal mortality and morbidity in the United States of America. *Bulletin of the World Health Organization*, *93*(5), 133-208. https://doi.org/10.2471/BLT.14.148627

Alberga, A. S., Edache, I. Y., Forhan, M., & Russell-Hayhew, S. (2019). Weight bias and healthcare utilization: A scoping review. *Primary Health Care Research & Development*, *20*(e116), 1-14. https://doi.org/10.1017/51463423619000227

Alberga, A. S., Pickering, B. J., Alix Hayden, K., Ball, G. D. C., Edwards, A., Jelinski, S., Nutter, S., Oddie, S., Sharma, A. M., & Russel-Mayhew, S. (2016). Weight bias reduction in health professionals: A systematic review. *Clinical Obesity*, *6*(3), 175-188. https://doi.org/10.1111/cob.12147

American College of Obstetricians and Gynecologists. (2015). Obesity in pregnancy. ACOG Practice Bulletin No. 156. *Obstetrics & Gynecology*, *126*(6), e112-e124. https://doi.org/10.1097/AOG.0000000000001211

American College of Obstetricians and Gynecologists. (2019). Ethical Considerations for the care of patients with obesity. ACOG Committee Opinion No. 763. *Obstetrics and Gynecology*, *133*(1), e90-e96. https://doi.org/10.1097/AOG.0000000000003015

American College of Obstetricians and Gynecologists. (2020). Physical activity and exercise during pregnancy and the postpartum period. ACOG Committee Opinion No. 804. *Obstetrics & Gynecology*, *135*(4), e178-e188. https://doi.org/10.1097/AOG.0000000000003772

Anderson, C. M., Monardo, R., Soon, R., Lum, J., Tschann, M., & Kaneshiro, B. (2017). Patient communication, satisfaction and trust before and after use of a standardized birth plan. *Hawaii Journal of Medicine and Public Heath*, *76*(11), 305-309. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5694973/

Atkinson, S., & McNamara, P. M. (2017). Unconscious collusion: An interpretative phenomenological analysis of the maternity care experiences of women with obesity (BMI > 30kg/m^2). *Midwifery*, *49*, 54-64. https://doi.org/10.1016/j.midw.2016.12.008

Attanasio, L., McPherson, M., & Kozhimannil, K. (2014). Positive childbirth experiences in US hospitals: A mixed-method analysis. *Maternal and Child Health Journal*, *18*(5), 1280-1290. https://doi.org/10.1007/s10995-013-1363-1

Bernecki DeJoy, S., Bittner, K., & Madel, D. (2016). A qualitative study of the maternity care experiences of women with obesity: "More than just a number on the scale". *Journal of Midwifery & Women's Health*, *61*(2), 217-223. https://doi.org/10.1111/jmwh.12375

Blainey, S. H., & Slade, P. (2015). Exploring the process of writing about and sharing traumatic birth experiences online. *British Journal of Health Psychology*, *20*(2), 243-260. https://doi.org/10.1111/bjhp.12093

Bombak, A. E., McPhail, D., & Ward, P. (2016). Reducing stigma: Interpreting "overweight" and "obese" women's experiences of weight-based discrimination in reproductive healthcare. *Social Science & Medicine*, *166*, 94-104. https://doi.org/10.1016/j.socscimed.2016.08.015

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Broughton, D. D., M & Moley, K. H. (2017). Obesity and female infertility: Potential mediators of obesity's impact. *Fertility and Sterility*, *104*(4) 840-847. https://doi.org/10.1016/j.fertnstert.2017.01.017.

Burnard, P., Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Analysing and presenting qualitative data. *British Dental Journal, 204*(8), 429-432. https://doi.org/10.1038/sj.bdj.2008.292

Butina, M. (2015). A narrative approach to qualitative inquiry. *Clinical Laboratory Science*, *28*(3), 190-196. https://hwmaint.clsjournal.ascls.org/

Bylund, C. L. (2005). Mothers' involvement in decision making during the birthing process: A quantitative analysis of women's online birth stories. *Health Communication*, *18*(1), 22-39. https://doi.org/10.1207/s15327027hc1801_2

Callister, L. C. (2004). Making meaning: Women's birth narratives. *Journal of Obstetric, Gynecologic and Neonatal Nurses*, *33*(4), 508-518. https://doi.org/10.1177/0884217504266898

Calvillo, J., Roman, I., & Roa, L. M. (2015). How technology is empowering patients? A literature review. *Health Expectations*, *18*(5), 643-652. https://doi.org/10.1111/hex.12089

Carlson, N. S., Corwin, E. J., & Lowe, N. K. (2017). Labor intervention and outcomes in women who are nulliparous and obese: Comparison of nurse-midwife to obstetrician intrapartum care. *Journal of Midwifery & Women's Health*, *67*(1), 29-39. https://doi.org/10.1111/jmwh.12579

Carlson, N. S., Leslie, S. L., & Dunn, A. (2018). Antepartum care of women who are obese during pregnancy: Systematic review of the current evidence. *Journal of Midwifery & Women's Health*, *63*(3), 259-272. https://doi.org/10.1111/jmwh12758

Carolan, M. (2006). Women's stories of birth: A suitable form of research evidence? *Women and Birth*, *19*, 65-71. https://doi.org/10.1016/j.wombi.2006.06.003

Carson, A., Chabot, C., Greyson, D., Shannon, K., Duff, P., & Shoveller, J. (2016). A narrative analysis of the birth stories of early-age mothers. *Sociology of Health & Illness*, *39*(6), 816-831. https://doi.org/10.1111/1467-9566.12518

Castro, A., & Andrews, G. (2018). Nursing lives in the blogosphere: A thematic analysis of anonymous online nursing narratives. *Journal of Advanced Nursing*, *74*, 329-338. https://doi.org/10.1111/jan.13411

Centers for Disease Control and Prevention. (2019, February 26). *Pregnancy-related deaths.* https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm

Centers for Disease Control and Prevention. (2020, March 4). *PCOS (polycystic ovary syndrome) and diabetes*. https://www.cdc.gov/diabetes/basics/pcos.html

Centers for Disease Control and Prevention. (2021, May 26). *Weight gain during pregnancy.* https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-weight-gain.htm

Chaffey, D. (2017, February 27). Global social media research summary 2017. *Smart Insights*. http://www.smartinsights.com/social-media-marketing/social-media-strategy/new-global-social-media-research/

Chang, J. (2022). Number of US bloggers in 2022/2023: Demographics, revenues, and best practices. *Finances Online*. https://financesonline.com/number-of-us-bloggers/

Chenail, R. J. (2011). Qualitative researchers in the blogosphere: Using blogs as diaries and data. *The Qualitative Report*, *16*(1), 249-254. http://www.nova.edu/ssss/QR/QR16-1/blog.pdf

Christenson, A., Torgerson, J., & Hemmingsson, E. (2020). Attitudes and beliefs in Swedish midwives and obstetricians towards obesity and gestational weight management. *BMC Pregnancy Childbirth*, *20*(1), 1-9. https://doi.org/10.1186/s12884-020-03438-1

Clandinin, D. J. (2013). *Engaging in narrative inquiry*. Taylor & Francis.

Clandinin, D. J., & Connelly, F. M. (2000). *Narrative inquiry: Experience and story in qualitative research*. Jossey-Bass.

Clark, J., & van Amerom, G. (2008). A comparison of blogs by depressed men and women. *Issues in Mental Health Nursing*, *29*(3), 243-264. https://doi.org/10.1080/01612840701869403

Coates, D., Thirukumar, P., Spear, V., Brown, G., & Henry, A. (2020). What are women's mode of birth preferences and why? A systematic scoping review. *Women and Birth*, *33*(4), 323-333. https://doi.org/10.1016/j.wombi.2019.09.005

Connelly, M. F., & Clandinin, J. D. (1990). Stories of experience and narrative inquiry. *Educational Researcher*, *19*(5), 2-14. https://doi.org/10.2307/1176100

Cook, K. M., LaMarre, A., Rice, C., & Friedman, M. (2019). “This isn’t a high-risk body”: Reframing risk and reducing weight stigma in midwifery practice. *Canadian Journal of Midwifery Research and Practice*, *18*(1), 26-34. http://hdl.handle.net/10214/17830

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches.* Sage.

Cunningham, J., Endacott, R., & Gibbons, D. (2018). Communication with health professionals: The views of pregnant women with a raised BMI. *British Journal of Midwifery*, *26*(9), 598-604. https://doi.org/10.12968/bjom.2018.26.9/598

Daiute, C. (2014). *Narrative inquiry: A dynamic approach*. Sage.

Davison, C. (2021). Women-centered care. *British Journal of Midwifery*, *29*(5), 246-248. https://doi.org/10.12968/bjom.2021.29.5.246

Declercq, E. R., Cheng, E. R., & Sakala, C. (2018). Does maternity care decision-making conform to shared decision-making standards for repeat cesarean and labor induction after suspected macrosomia? *Birth*, *45*(3), 236-244. https://doi.org/10.1111/birt.12365

Declercq, E. R., Sakala, C., Corry, M. P., Applebaum, S., & Herrlich, A. (2013, June). Listening to mothers III: New mothers speak out. *Childbirth Connection.* http://transform.childbirthconnection.org/wp-content/uploads/2013/06/LTM-III_NMSO.pdf

DeJoy, S. B., Bittner, K., & Mandel, D. (2016). A qualitative study of the maternal care experiences of women with obesity: “More than just a number on the scale.” *Journal of Midwifery & Women’s Health*, *61*(2), 217-233. https://doi.org/10.1111/jmwh.12375

Dencker, A., Premberg, A., Olander, E. K., McCourt, C., Haby, K., Dencker, S., Glantz, A., & Berg, M. (2016). Adopting a healthy lifestyle when pregnant and obese–an interview study three years after childbirth. *BMC Pregnancy and Childbirth, 16*(1), 1-10. https://doi.org/10.1186/s12884-016-0969-x

DePoy, E., & Gitlin, L. N. (2016). *Introduction to research: Understanding and applying multiple strategies* (5th ed.). Elsevier.

Dewey, J. (1938/1997). *Experience and education*. Touchstone.

Dieterich, R., & Demirci, J. (2020). Communication practices of healthcare professionals when caring for overweight/obese pregnant women: A scoping review. *Patient Education and Counselling*, *103*(10), 1902-1912. https://doi.org/10.1016/j.pec.2020.05.011

Dinsdale, S., Branch, K., Cook, L., & Shucksmith, J. (2016). "As soon as you've had the baby that's it…" a qualitative study of 24 postnatal women on their experience of maternal obesity care pathways. *BMC Public Health*, *16*, 625. https://doi.org/10.1186/s12889-016-3289-1

DiPietro, L., Evenson, K. R., Bloodgood, B., Sprow, K., Troiano, R. P., Piercy, K. L., Vaux-Bjerke, A., & Powell, K. E. (2019). Benefits of physical activity during pregnancy and postpartum: An umbrella review. *Medicine and Science in Sports and Exercise*, *51*(6), 1292-1302. https://doi.org/10.1249/MSS.0000000000001941

Divall, B., Spiby, H., Nolan, M., & Slade, P. (2017). Plans, preferences or going with the flow: An online exploration of women's views and experiences with birth plans. *Midwifery*, *54*, 29-34. http:// doi.org/10.1016/j.midw.2017.07.020

Downe, S., Finlayson, K., Oladapo, O., Bonet, M., & Gülmezoglu, A. M. (2018). What matters to women during childbirth: A systematic qualitative review. *PLoS One*, *13*(4), e0194906. http://doi.org/10.1371/journal.pone.0194906

Doyle, C., Lennox, L., & Bell, D. (2013). A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ Open*, *3*(1), e001570. https://bmjopen.bmj.com/content/3/1/e001570.short

Driscoll, A. & Gregory, C.W. (2020). *Increases in prepregnancy obesity: United States, 2016-2019*. (NCHS Brief No. 392). https://www.cdc.gov/nchs/products/databriefs/db392.htm

Eastham, L. A. (2011). Research using blogs for data: Public documents or private musings? *Research in Nursing & Health*, *34*(4), 353-361. https://doi.org/10.1002/nur.20443

Edwards, K. J., Duff, J., & Walker, K. (2014). What really matters? A multi-view perspective of one patient's hospital experience. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, *49*(1), 122-126. https://doi.org/10.1056/NEJMp1211775

Ekland, J. H., Homstrom, I. K., Kumlin, T., Kaminsky, E., Skoglund, K., Hoglander, J., Sundler, A. J., Conden, E., & Meranius, M. S. (2019). "Same or different? A review of person-centered and patient-centered care. *Patient Education and Counseling*, *102*(1), 3-11. https://doi.org/10.1016/j.pec.2018.08.029

Ellis, S., Rosenblum, K., Miller, A., Peterson, K. E., & Lumeng, J. C. (2014). Meaning of the terms "overweight" and "obese" among low-income women. *Journal of Nutrition Education and Behavior*, *46*(4), 299-303. https://doi.org/10.1016/j.jneb2013.08.006

Farley, C., & Widman, S. (2001). The value of birth stories. *International Journal of Childbirth Education*, *16*(3), 22-25.

https://www.proquest.com/openview/95e7c46fd4a1b1bceb63e37254973375/1?pq-origsite=gscholar&cbl=32235

Faucher, M. A., Mirabito, A. M., Greig, Y., Williams, A. F., & Coulter-Smith, M. (2021). Obesity matters: The skills that strengthen midwifery practice when caring for obese pregnant women. *British Journal of Midwifery*, *29*(5), 278-285. https://doi.org/10.12968/bjom.2021.29.5.278

Fawcett, H., & Shrestha, L. (2016). Blogging about sexual assault: A thematic analysis. *Journal of Forensic Practice*, *18*(1), 39-51. https://doi.org/10.1108/JFP-05-2015-0032

Feedspot. (2019, July 22). *Top 100 pregnancy blogs, websites, and newsletters in 2019*. https://blog.feedspot.com/pregnancy_blogs/

Fitzsimons, K. J., Modder, J., & Greer, I. A. (2009). Obesity and pregnancy: Risks and management. *Obstetric Medicine*, *2*(2), 52-62. https://doi.org/10.1258/om.3009.090009.

Flint, S. W. (2021). Time to end weight stigma in healthcare. *Eclinical Medicine*, *34*. https://doi.org/10.1016/j.eclinm.2021.100810

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

Garbett, K., Harcourt, D., & Buchanan, H. (2017). Using online blogs to explore positive outcomes after burn injuries. *Journal of Health Psychology*, *12*(13), 1755-1766. https://doi.org/0.1177/1359105316638549

Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report*, *8*(4), 597-606. http://www.nova.edu/ssss/QR/QR8-4/golafshani.pdf

Green, B. (2013). Narrative inquiry and nursing research. *Qualitative Research Journal*, *13*(1), 62-71. https://doi.org/10.1108/14439881311314586

Grenier, L. N., Atkinson, S. A., Mottola, M. F., Wahoush, O., Thabane, L., Xie, F., Vickers-Manzin, J., Moore, C., Hutton, E. K., & Murray-Davis, B. (2021). Be healthy in pregnancy: Exploring factors that impact pregnant women's nutrition and exercise behaviors. *Maternal & Child Nutrition*, *17*(1), 1-9. https://doi.org/10.1111/mcn.13068

Haines, H. M., Rubertsson, C., Pallant, J. F., & Hildingsson, I. (2012). The influence of women's fear, attitudes, and beliefs of childbirth on mode and experience of birth. *BMC Pregnancy and Childbirth*, *12*(1). https://doi.org/10.1186/1471-2393-12-55

Hallam, J., Howard, C., Thomas, M., & Locke, A. (2019). Empowering women through the positive birth movement. *Journal of Gender Studies*, *28*(3), 330–341. https://doi.org/10.1080/09589236.2018.1469972

Haydon, G., Browne, G., & van der Riet, P. (2018). Narrative inquiry as a research methodology exploring person centered care in nursing. *Collegian*, *25*(1), 125-129. https://doi.org/10.1016/j.colegn.2017.03.001

Heilferty, C. M. (2018). "Hopefully this will all make sense at some point": Meaning and performance in illness blogs. *Journal of Pediatric Oncology Nursing*, *35*(4), 287-295. https://doi.org/10.1177/1043454218764880

Heslehurst, N., Russell, S., Brandon, H., Johnston, C., Summerbell, C., & Rankin, J. (2013). Women's perspectives are required to inform the development of maternal obesity services: A qualitative study of obese pregnant women's experiences. *Health Expectations*, *18*, 969-981. https://doi.org/10.1111/hex.12070

Holton, S., East, C., & Fisher, J. (2017). Weight management during pregnancy: A qualitative study of women's and care providers' experiences and perspectives. *BMC Pregnancy and Childbirth*, *17*(1), 1-10. https://doi.org/10.1186/s12884-017-1538-7

Holton, S., Fisher, J., Nguyen, H., Brown, W. J., & Tran, T. (2019). Prepregnancy body mass index and the risk of antenatal depression and anxiety. *Women and Birth*, *32*(6), e508-e514. https://doi.org/10.1016/j.wombi.2019.01.007

Hookway, N. (2008). 'Entering the blogosphere': Some strategies for using blogs in social research. *Qualitative Research*, *8*(1), 91-113. https://doi.org/10.1177/1468794107085298

Hsu, M. Y., & McCormack, B. (2011). Using narrative inquiry with older people to inform practice and service developments. *Journal of Clinical Nursing*, *21*, 841-849. https://doi.org/10.1111/j.1365-27-2.2011.03851.x

Hurst, D. J., Schmuhl, N. B., Voils, C. I., & Atony, M. (2021). Prenatal care experiences among pregnant women with obesity in Wisconsin, United States: A qualitative quality improvement assessment. *BMC Pregnancy and Childbirth*, *21*(1), 1-13. https://doi,org/10.1186/s12884-021-03629-4

Incollingo Rodriguez, A. C., Dunkel Schetter, C., & Tomiyama, A. J. (2020). Weight stigma among pregnant and postpartum women: A new context of stigmatization. *Stigma and Health, 5*(2), 209–216. https://doi.org/10.1037/sah0000191

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. National Academy Press.

Jaworska, S. (2018). 'Bad' mums tell the 'untellable': Narrative practices and agency in online stories about postnatal depression on Mumsnet. *Discourse, Context & Media*, 25, 25-33. https://doi.org/10.1016/j.dcm.2017.11.002.

Jevitt, C. M. (2019). Obesity. In R. G. Jordan, C. L. Farley, & K. T. Grace (Eds.), *Prenatal and postnatal care: A woman-centered approach* (2nd ed., pp. 625-636). John Wiley & Sons.

Johnson, N. L., Scott, S. F., & Brann, M. (2020). "Our birth experiences are what binds us": Women's motivations for storytelling about birth to build motherwisdom. *Communication Studies*, *71*(4), 649–668. https://doi.org/10.1080/10510974.2020.1771391

Jolles, M. W., de Vries, M., Hollander, M. H., & van Dillen, J. (2019). Prevalence, characteristics and satisfaction of women with a birth plan in The Netherlands. *Birth*, *46*(4), 686-692. https://doi.org/10.1111/birt.12451

Jones, C., & Jomeen, J. (2017). Women with a BMI > 30 kg/m2 and their experience of maternity care: A meta ethnographic synthesis. *Midwifery*, *53*, 87-95. https://doi.org/10.1016/j.midw.2017.07.011v5-433-446Jonew530.pdf

Jones, C. W., & Lynn, M. R. (2018). Blogs written by families during their child's hospitalization: A thematic narrative analysis. *Journal of Pediatric Nursing*, *41*, 110-116. https://doi.org/10.1016/j.pedn,2018.03.011.

Jones, M., & Alony, I. (2008). Blogs – The new source of data analysis. *Issues in Informing Science and Information Technology*, *5*, 443-446. http://proceedings.informingscience.org/InSITE2008/IISIT

Joyce, M. (2015). Using narrative in nursing research. *Nursing Standard*, *29*(38), 36-41. https://doi.org/10.7748/ns.29.38.36.e9008

Keim-Malpass, J., Baernholdt, M., Erickson, J. M., Ropka, M. E., Schroen, A. T., & Steeves, R. H. (2013). Blogging through cancer: Young women's persistent problems shared online. *Cancer Nursing*, *36*(2), 163-172. https://doi.org/10.1097/NCC.0b013e31824eb879

Kelley, A.S., Qin, Y., Marsh, E. E. & Dupree, J. M. (2019). Disparities in accessing infertility care in the United States: results from the National Health and Nutrition Examination Survey, 2013-16. *Fertility and Sterility*, *112*(3), 562-568. https://doi.org/10.1016/j.fertnstert.2019.04.044.

Kim, J. (2016). *Understanding narrative inquiry*. Sage.

Kirkpatrick, H. (2008). A narrative framework for understanding experiences of people with severe mental illness. *Archives of Psychiatric Nursing*, *22*(2), 61-68. https://doi.org/10.1016/j.apnu.2007.12.002

Knight-Agarwal, C. R., Williams, L. T., Davis, D., Davey, R., Shepard, R., Downing, A., & Lawson, K. (2016). The perspectives of obese women receiving antenatal care: A qualitative study of women's experiences. *Women and Birth*, *29*, 189-195. https://doi.org/10.1016/j.wombi.2015.10.008

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *American Journal of Occupational Therapy*, *45*(3), 214-222. https://doi.org/10.5014/ajot.45.3.214

Kumpulainen, S. M., Girchenko, P., Lahti-Pulkkinen, M., Reynolds, R. M., Tuovinen, S., Pesonen, A., Heinonen, K., Kajantie, E., Pia, M., & Hamalainen, E. (2018). Maternal early pregnancy obesity and depressive symptoms during and after pregnancy. *Psychological Medicine, 48*(14), 2353-2363. http://doi.org/10.1017/S0033291717003889

Lauridsen, D. S., Sandoe, P., & Holm, L. (2018). Being targeted as a "severely overweight pregnant woman" – A qualitative interview study. *Health Expectations*, *21*, 878-886. https://doi.org/10.1111/hex.12681

Lavender, T., & Smith, D. M. (2015). Seeing it through their eyes: A qualitative study of the pregnancy experiences of women with a body mass index of 30 or more. *Health Expectations*, *19*, 222-233. https://doi.org/10.1111/hex.12339

Lin, A. W., Bergomi, E. J., Dollahite, J. S., Sobal, J., Hoeger, K. M., & Lujan, M. E. (2018). Trust in physicians and medical experience beliefs differ between women with and without polycystic ovary syndrome. *Journal of the Endocrine Society*, *2(*9), 1001-1009. https://doi.org/10.1210/js.2018-00181

Lingetun, L., Fungbrant, M., Claesson, M., & Baggens, C. (2017). 'I just want to be normal' – A qualitative study of pregnant women's blogs who present themselves as overweight or obese. *Midwifery*, *49*, 65-71. https://doi.org/10.1016/j.midw.2017.01.015

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage.

Lindqvist, M., Eurenius, E., Persson, M., & Mogren, I. (2017). Change of lifestyle habits – Motivation and ability reported by pregnant women in northern Sweden. *Sexual & Reproductive Healthcare*, *13*, 83-90. https://doi.org/10.1016/j.srhc.2017.07.001

Liu, P., Xu, L., Wang, Y., Zhang, Y., Du, Y., Sun, Y., & Wang, Z. (2016, August 18). Association between perinatal outcomes and maternal prepregnancy body mass index. *Obesity Reviews*, *17*. https://doi.org/10.1111/obr.12455

Lothian, J. (2006). Birth plans: The good, the bad and the future. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *35*(2), 295-303. https://doi.org/10.1111/j.1552-6909.2006.00042.x

Lovering, M. E., Rodgers, R. F., George, J. E., & Franko, D. L. (2018). Exploring the tripartite influence model of body dissatisfaction in postpartum women. *Body Image*, *24*, 44-55. https://doi.org/10.1016/j.bodyim.2017.12.001

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

Maclellan, J. (2015). Healing identity by telling childbirth stories on the internet. *British Journal of Midwifery*, *23*(7), 180-185. ttps://doi.org/10.12968/bjom.2015.23.7.477

McCloud, M. B., & Barosso, J. (2021). Experiences of pregnant women with obesity. *Nursing for Women's Health*, *25*(3), 179-186. https://doi.org/10.1016/j.nwh.2021.03.004

McGuigan, R. D., & Wilkinson, J. M. (2015). Obesity and healthcare avoidance: A systematic review. *AIMS Public Health*, *2*(1), 56–63. https://doi.org/10.3934/publichealth.2015.1.56

Megregian, M., Emeis, C., & Nieuwenhuijze, M. (2020). The impact of shared decision-making in perinatal care: A scoping review. *Journal of Midwifery & Women's Health*, *65*(6), 777-788. https://doi.org/10.1111/jmwh.13128

Merriam, S. B. (Ed.). (2002). Assessing and evaluating qualitative research. *Qualitative research in practice: Examples for discussion and analysis* (p. 31). Jossey-Bass.

Mesinger, J. L., Tylka, T. L., & Calamari, M. E. (2018). Mechanisms underlying weight status and healthcare avoidance in women: A study of weight stigma, body-related shame and guilt and healthcare stress. *Body Image*, *25*, 139-147. https://doi.org/10.1016/j.bodyim.2018.03.001

Mijatovic-Vukas, J., Capling, L., Cheng, S., Stamatakis, E., Louie, J., Cheng, N. W., Markovic, T., Ross, G., Senior, A., Brand-Miller, J. C., & Flood, V. M. (2018). Associations of diet and physical activity with risk for gestational diabetes mellitus: A systematic review and meta-analysis. *Nutrients*, *10*(6), 698. https://doi.org/10.3390/nu10060698

Miller, W. R., & Rose, G. S. (2009). Toward a theory of motivational interviewing. *American Psychologist*, *64*(6), 527–537. https://doi/org/10.1037/a0016830

Mills, A., Schmied, V. A., & Dahlen, H. G. (2013). 'Get alongside us,' women's experiences of being overweight and pregnant in Sydney, Australia. *Maternal & Child Nutrition*, *9*(3), 309-321. https://doi.org/10.1111/j.1740-8709.2011.00386.x

Moore, D., Ayers, S., & Drey, N. (2016). A thematic analysis of stigma and disclosure for perinatal depression on an online forum. *JMIR Mental Health*, *3*(2), e18. https://doi.org/10.2196/mental.5611

Mulherin, K., Miller, Y. D., Barlow, F. K., Diedrichs, P. C., & Thompson, R. (2013). Weight stigma in maternity care: Women's experiences and care providers' attitudes. *Bio Med Central Pregnancy & Childbirth*, *13*(1), 19. https://doi.org/10.1186/1471-2393/13/19

Nichols, H. (2017, March 15). *Six of the best pregnancy blogs for parents-to-be*. Medical News Today. https://www.medicalnewstoday.com/articles/316367.php

Nikolopoulos, H., Mayan, M., MacIsaac, J., Miller, T., & Bell, R. C. (2017). Women's perceptions of discussions about gestational weight gain with health care providers during pregnancy and postpartum: A qualitative study. *BMC Pregnancy and Childbirth*, *17*(1), 1-9. https://doi.org/10.1186/s12884-017-1257-0

Nilver, H., Begley, C., & Berg, M. (2017). Measuring women's childbirth experiences: A systematic review for identification and analysis of validated instruments. *BMC Pregnancy and Childbirth*, *17*(1), 1-19. https://doi.org/10.1186/s12884-017-1356-

O'Brien, O. A., Lindsay, K. L., McCarthy, M., McGloin, A. F., Kennelly, M., Scully, H. A., & McAuliffe, F. M. (2017). Influences on the food choices and physical activity behaviors

of overweight and obese pregnant women: A qualitative study. *Midwifery*, *47*, 28-35. http://doi.org/10.1016/j.midw.2017.02.003

Office on Women's Health. (2018). *Pregnancy and body image*. https://www.womenshealth.gov/mental-health/body-image-and-mentalhealth/pregnancy-and-body-image/

Olander, E. K. (2020). Maternal obesity and stigma. In *Obesity and Obstetrics* (pp. 335-341). Elsevier.

Ollerenshaw, J. A., & Creswell, J. W. (2002). Narrative research: A comparison of two restorying data analysis approaches. *Qualitative Inquiry*, *8*(3), 329-347. https://doi.org/10.1177/10778004008003008

Patton, M. Q. (2015). *Qualitative research & evaluation methods* (4th ed.). Sage.

Peters, L. D. (2014). You are what you wear: How plus-size fashion figures in fat identity formation. *Fashion Theory*, *18*, 45-71. https://doi.org/10.2752/17517411

Phelan, S. (2010). Pregnancy: A "teachable moment" for weight control and obesity prevention. *American Journal of Obstetrics & Gynecology*, *202*(2), 135e1-e8. https://doi.org/10.1016/j.ajog.2009.06.008

Phelan, S. M., Burgess, D. J., Yeazel, M. W., Hellerstedt, W. L., Griffin, J. M., & van Ryn, M. (2015). Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obesity Reviews*, *16*, 319-327. https://doi.org/10.1111/obr.12266

Pienaar, L. & Viser, M. (2012). An exploration of the experiences of adolescents living with HIV. *Vulnerable Children and Youth Studies: An International Journal for Research, Policy and Care*, *7*(1), 66-74. https://doi.org/10.1080/17450128.2011.647731

Pinheiro, T. V., Goldani, M. Z., & IVAPSA group. (2018). Maternal prepregnancy overweight/obesity and gestational diabetes interaction on delayed breastfeeding initiation. *PLoS one*, *13*(6), 1-11. https://doi.org/10.1371/jounal.pone.0194879

Pinilla, S., Weckbach, L. T., Alig, S. K., Bauer, H., Noerenberg, D., Singer, K., & Tiedt, S. (2013). Blogging medical students: A qualitative analysis. *GMS Z Med Ausbid*, *30*(1), 1-12. https://doi.org/10.3205/zma000852

Plus Size Birth (n.d.). Plus Size Pregnancy Support. https://plussizebirth.com

Plus Size Birth (n.d) Plus Size Birth Stories. https://plussizebirth.com/category/plus-size-birth-stories/

Poston, L. (2017). Obesity in pregnancy: Where are we, where should we go? *Midwifery*, *49*, 4-6. https://doi.org/101016/j.midw.2017.01.007

Provost, M. P., Acharya, K. S., Acharya, C. R., Yeh, J. S., Steward, R. G., Eaton, J. L., Goldfarb, J. M., & Muasher S. J. (2016). Pregnancy outcomes decline with increasing body mass index: Analysis of 239,127 fresh autologous in vitro fertilization cycles from the 2008-2010 Society for Assisted Reproductive Technology registry. *Fertility and Sterilization*, *105*(3), 663-669. https://doi.org/10.1016/j.fertnstert.2015.11.008

Puhl, R. M. & Himmelstein, M.S. (2018). Adolescent preferences for weight terminology used by health care providers. *Pediatric Obesity*, *13*(9), 533-540. https://doi.org/10.1111/ijpo.12275

Reed, R. (2011). Sharing stories: Reclaims birth knowledge. *Midwifery Today*, (99), 13-14. https://europepmc.org/article/med/21999048

Riess H. (2017). The science of empathy. *Journal of Patient Experience*, *4*(2), 74-77. https://doi.org/10.1177/2374373517699267

Relph, S., Guo, Y., & Harvey, A. L. J. (2021). Characteristics associated with uncomplicated pregnancies in women with obesity: A population-based cohort study. *BMC Pregnancy Childbirth*, *21*(1), 1-10. https://doi.org/10.1186/s12884-021-03663-2

Richardson, M. G., Raymond, B. L., Baysinger, C. L., Kook, B. T., & Chestnut, D. H. (2018). A qualitative analysis of parturients' experiences using nitrous oxide for labor analgesia: It is not just about pain relief. *Birth Issues in Prentatal Care*, *46* (1), 97-104. https://doi-org/10.1111/birt.12374

Riessman, C. K. (2003). Narrative analysis. In M. S. Lewis-Beck, A. Bryman, & T. Futing Liao (Eds.), *The Sage encyclopedia of social science research methods*. Sage.

Romeo, L., & Lee, Y. (2015). Exploring apparel purchase issues with plus-size female teens. *Journal of Fashion Marketing and Management*, *19*(2), 120-135. https://doi.org/10.1108/JFMM-02-2014-0012.

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterford, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality & Quantity*, *4*, 1893-1907. https://doi.org/10.1007/s11135-017-0574-8

Savin-Baden, M., & Van Niekerk, L. (2007). Narrative inquiry: Theory and practice. *Journal of Geography in Higher Education*, *31*(3), 459-472. https://doi.org/10.1080/03098260601071324

Sarwer, D. B. & Polonsky, H.M. (2016). The psychosocial burden of obesity. *Endocrinology and Metabolism Clinics of North America*, *45*(3), 677-688. https://doi.org/10.1016/j.ecl.2016.04.016

Schmied, V. A., Duff, M., Dahlen, H. G., Mills, A. E., & Kolt, G. S. (2011). 'Not waving but drowning': A study of the experiences and concerns of midwives and other health professionals caring for obese childbearing women. *Midwifery*, *27*(4), 424-430. https://doi.org/10.1016/j.midw.2010.02.010

Shapira, A. L., Handzel, R., & Lorczyn, A. D. (2017). The lived experience of Parkinson's patients' blogs. *Israel Medical Association Journal*, *19*(1), 685-690. https://www.ima.org.il/MedicineIMAJ/viewarticle.aspx?year=2017&month=11&page=685

Simoni, A. D., Shanks, A., Mant, J., & Skelton, J. R. (2014). Making sense of patients' internet forums: A systematic method using discourse analysis. *British Journal of General Practice*, e178-e180. https://doi.org/10.3399/bjgp14X677671

Sinaiko, A. D., Szumigalski, K., Eastman, D., & Chien, A. T. (2019). *Delivery of patient centered care in the US health care system: What is standing in its way?* Academy Health. https://academyhealth.org/sites/default/files/deliverypatientcenteredcare_august2019.pdf

Smith, B. (2016). Narrative analysis. In E. Lyons & A. Coyle (Eds.), *Analyzing qualitative data in psychology* (2nd ed., pp. 202-221). Sage.

Snee, H. (2013). Making ethical decisions in an online context: Reflections on using blogs to explore narratives of experience. *Methodological Innovations Online*, *8*(2), 52-67. https://doi.org/10.4256/mio.2013.013

Solmi, F., & Morris, S. (2018). Overweight and obese prepregnancy BMI is associated with higher hospital costs of childbirth in England. *BMC Pregnancy and Childbirth*, *18*(1), 253. https://doi.org/10.1186/s12884-018-1893-z

Stubert, J., Reister, F., Hartmann, S., & Janni, W. (2018). The risks associated with obesity in pregnancy. *Deutsches Aerzteblatt International*, *115*(16), 276-283. https://doi.org/10.3238/arztebl.2018.0276.

Talmor A., Dunphy, B. (2015) Female obesity and infertility. *Best Practice & Research Clinical Obstetrics & Gynaecology*, *29*(4), 498-506. https://doi.org/10.1016/j.bpobgyn.2014.10.014.

Thomas, C. M., Allison, R., & Latour, J. M. (2018). Using blogs to explore the lived experience of life after stroke: "A journey of discovery I never wanted to take." *Journal of Advanced Nursing*, *74*(3), 579-590. https://doi.org/10.1111/jan.13457

Thomas, S. L., Hyde, J., Karunaratne, A., Hebert, D., & Komesaroff, P. (2008). Being 'fat' in today's world: A qualitative study of the lived experiences of people with obesity in Australia. *Health Expectations*, *11*(4). https://doi.org/10.1111/j.1369-7625.2008.00490.x

Thorbjornsdottier, K. E., Karlsen, I. E., Dahl, B., & Roseth, I. (2020). "Talk to me, not at me": Obese women's experiences of birth and their encounter with birth attendants – a qualitative study. *International Journal of Qualitative Studies on Health and Well-being*, *15*(1). https://doi.org/10.1080/17482631.2020.1845286

Tierney, S., Stringer, E., Fox, J. R. E., McGowan, L., & Furber, C. (2010). Difficulties in recruiting pregnant women with eating or weight issues. *British Journal of Midwifery*, *18*(11), 717-723. https://doi.org/10.12968/bjom.2010.18.11.79559

Timmons, J. (2019, April 8). *The best pregnancy blogs of 2019*. Healthline. https://www.healthline.com/health/pregnancy/best-blogs-of-the-year#1

Urbańska, A., & vel Dziurawiec, K. Z. (2019). Obesity and body image. *Current Problems of Psychiatry*, *20*(4), 301-308. https://doi.org/10.2478/cpp-2019-0022

van Stenus, C. M. V., Gotink, M., Boere-Boonekamp, M., Sools, A., & Need, A. (2017). Through the client's eyes: Using narratives to explore the experiences of care transfers during pregnancy, childbirth, and the neonatal period. *BMC Pregnancy and Childbirth*, *17*, 1-12. https://doi.org/10.1186/s12884-017-1369-6

Vernini, J. M., Moreli, J. B., Magalhaes, C. G., Costa, R. A. A., Rudge, M. V. C., & Calderon, I. M. P. (2016). Maternal and fetal outcomes in pregnancies complicated by overweight and obesity. *Reproductive Health*, *13*(1), 100. https://doi.org/ 10.1186/s12978-016-0206-0

Volger, S., Vetter, M. L., Dougherty, M., Panigrahi, E., Egner, R., Webb, V., Thomas, J. G., Sarwer, D. B., & Wadden, T. A. (2012). Patient's preferred terms for describing their excess weight: Discussing obesity in clinical practice. *Obesity*, *20*(1), 147-150. http://doi.org/10.1038/oby.2011.217

Vora, R., & Patil, P. (2015). Health related quality of life in females suffering from polycystic ovary syndrome (PCOS). *Indian Journal of Physiotherapy and Occupational Therapy*, *9*(4), 80. https://www.ijpot.com

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

Wang, C. C., & Geale, S. K. (2015). The power of story: Narrative inquiry as a methodology in nursing research. *International Journal of Nursing Science*, *2*(2), 195-198. https://doi.org/10.1016.j.ijnss.2015.04.014.

Weeks, A., Halili, L., Liu, R. H., Deonandan, R., & Adamo, K. B. (2020). Gestational weight gain counselling gaps as perceived by pregnant women and new mothers: Findings from the electronic maternal health survey. *Women and Birth*, *33*(1), e88-e94. https://doi.org/10.1016/j.wombi.2019.02.005

Wei, Y., Yang, H., Zhu, W., Liu, X., Meng, W., & Wang, Y. (2016). Risk of adverse pregnancy outcomes stratified for prepregnancy body mass index. *The Journal of Maternal-Fetal & Neonatal Medicine*, *29*(13), 2205-2209. https://doi.org/10.3109/14767058.2015.1081167.

Wertz, F. J., Charmaz, K., McMullen, L. M., Josselson, R., Anderson, R., & McSpadden, E. (2011). *Five ways of doing qualitative analysis: Phenomenological psychology*, *grounded theory, discourse analysis, narrative research, and intuitive inquiry*. Guildford Press.

Wilkinson, S. A., Poad, D., & Stapleton, H. (2013). Maternal overweight and obesity: A survey of clinicians' characteristics and attitudes, and their responses to their pregnant clients. *BioMed Central Pregnancy and Childbirth*, *13*, 117. https://doi.org/10.1186/1471-2393-13-117

Wilson, E., Kenny, A., & Dickson-Swift, V. A. (2015). Using blogs as a qualitative health research tool: A scoping review. *The International Journal of Qualitative Methods*,*14*(5). https://doi./org/10.1177/1609406915618049

Windham, G. C., Anderson, M., Lyall, K., Daniels, J. L., Kral, T. V. E., Croen, L. A., Levy, S. E., Bradley, C. B., Cordero, C., Young, L., & Shieve, L. A. (2019). Maternal prepregnancy body mass index and gestational weight gain in relation to autism spectrum disorder and other developmental disorders in offspring. *Autism Research*, *12*(2), 316-327. https://doi.org/10.1002/aur.2057

World Health Organization. (2017, October 10). *World obesity day: Understanding the social consequences of obesity*. https://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/news/news/2017/10/world-obesity-day-understanding-the-social-consequences-of-

obesity#:~:text=Stigma%20is%20a%20fundamental%20cause,and%20avoidance%20of%20medical%20care.

World Health Organization. (2018). *Quality, equity, dignity: The network to improve quality of care for maternal, newborn, and child health – strategic objectives*. https://apps.who.int/iris/bitstream/handle/10665/272612/9789241513951-eng.pdf?ua=1

World Health Organization. (2022.). *Controlling the global obesity epidemic*. https://www.who.int/activities/controlling-the-global-obesity-epidemic

Zhao, R., Xu, L., Wu, M. L., Huang, S. H., & Cao, X. J. (2018). Maternal prepregnancy body mass index, gestational weight gain influence birth weight. *Women and Birth*, *31*(1), e20-e25. https://doi.org/10.1016/j.wombi.2017.06.003