



Obese women's experiences of encounters with midwives and physicians during pregnancy and childbirth

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ABSTRACT

Objective: to describe obese women's experiences of encounters with midwives and physicians during pregnancy and childbirth.

Design: a qualitative study using a phenomenological approach. Data were collected by means of interviews that were tape-recorded.

Setting: the women's homes or at a hospital in western Sweden.

Participants: 10 women with body mass index > 30, three primiparous and seven multiparous, who had given birth at a hospital in western Sweden in the period between October 2006 and September 2007 were interviewed four to six weeks after childbirth.

Findings: the meaning of being both obese and pregnant is living with a constant awareness of the body, and its constant exposure to the close observation and scrutiny of others. It involves negative emotions and experiences of discomfort. Feelings of discomfort increase as a result of humiliating treatment, whilst affirmative encounters alleviate discomfort and provide a sense of wellbeing.

Conclusion and implications for practice: obese pregnant women are a vulnerable group because obesity is highly visible. Caregivers tend to focus on providing care to obese patients somatically, but are additionally in need of knowledge about care from the woman's point of view. Many obese women have negative experiences of health care that they have to overcome. It is necessary to individualise care for obese pregnant women, which involves taking time to give the women an opportunity to tell their own story. Caregivers have to promote health but it has to be done honestly and respectfully. In order to avoid judgemental attitudes and causing increased suffering for obese pregnant women, midwives and physicians need to be conscious of, reflect upon and verbalise their own attitudes and power.

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Introduction

Excess weight and obesity are widely recognised and escalating problems that pose a serious threat to global health (WHO, 2006). Consequently, the proportion of women who have excess weight or obesity when registering for maternal care has increased. Maternal excess weight and obesity are, as well known, associated with obstetrical risks and neonatal outcomes, such as gestational diabetes, high blood pressure, thrombosis, still birth, caesarean delivery and meconium staining (Cedergren, 2004; Krishnamoorthy et al., 2006).

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Caregivers' knowledge about medical complications due to obesity gives rise to concerns about possible risks (Brown, 2006; Krishnamoorthy et al., 2006). Furthermore, for midwives and obstetricians, maternal obesity results in practical difficulties when investigating the fetus's growth and position by external palpations, and getting a reliable picture of the fetus's development (Krishnamoorthy et al., 2006).

Living with obesity has social, psychological and economical effects on a person's whole life. Obesity is a condition associated with negative attitudes and discrimination within Western societies (Cramer and Steinwert, 1998; Puhl and Brownell, 2001; Brown, 2006). The individual is considered to be personally responsible for her/his overweight, and obesity is associated with laziness, passivity and a lack of self-discipline (Puhl and Brownell, 2001). Aspects of stereotyping, stigmatisation and discrimination have negative consequences for quality of life and psychological

wellbeing (Kolatkina et al., 2001). Brown et al. (2006) explain that the obese patient's own feeling of guilt, that is a sense of stigmatisation and anticipated negative stereotyping, influences the contact with health care negatively and makes individual encounters with caregivers even more difficult. Research among obese people reveals poor experiences in relation to health care, including negative attitudes from nurses and physicians (Kristeller and Hoerr, 1997; Puhl and Brownell, 2001).

Several studies highlight important factors for pregnant women in encounters with midwives (Berg et al., 1996; Halldórsdóttir and Karlsdóttir, 1996a; Lundgren, 2004; Nilsson and Lundgren, 2007). These factors include support and encouragement on the woman's own terms, to be treated as an individual, have a trusting relationship with the midwife, and to be assured of the midwife's presence. Likewise, the woman's own responsibilities, participation, trust in her own capability and a desire to give birth are regarded as essential.

The woman's sense of self during the birth experience seems to involve the perception of being in a private world where she is vulnerable, insecure and dependent. The woman is exposed physically among strangers in an unfamiliar environment and her body is functioning outside her control (Halldórsdóttir and Karlsdóttir, 1996b).

Women's experiences of pregnancy, childbirth and encounters with midwives are well documented, as is discrimination towards people who are obese. However, to the authors' knowledge, research relating to obese and pregnant women's experiences of encounters with and treatment by caregivers is limited. The aim of this study is to describe obese women's experiences of encounters with midwives and physicians during pregnancy and childbirth.

Method

A phenomenological approach was adopted. This approach is suitable when complex phenomena of the everyday world, such as feelings and experiences, are studied. The aim is to describe experiences of a phenomenon as the individual lives it, so called life-world experiences, and its inherent meaning (Karlsson, 1995).

The phenomenological method used in this study, the empirical phenomenological psychological method, is grounded in Husserl's phenomenological philosophy, and reflects a life-world perspective. It is further influenced by hermeneutical philosophers, such as Heidegger and Gadamer (Karlsson, 1995).

The point of departure for investigation is the individuals' descriptions of experiences in relation to events and situations in their everyday life. From those descriptions, the inherent meaning is traced out and uncovered in the analysis. In a phenomenological manner, the interviewer is striving for openness and intends to enter the interview situation without expectations and pre-understandings (Karlsson, 1995).

Inclusion and exclusion criteria

Women who had a body mass index (BMI) > 30 at registration at a maternal care clinic, primiparous or multiparous, regardless of morbidities and risks, were Swedish-speaking, and who had given birth at a hospital in western Sweden were invited to participate. Women who had been delivered by either of the researchers were excluded. The women received both oral and written information during their stay in hospital after delivery. The information included the aim of the study, and that the women should have had an excess body weight at the beginning of their pregnancy. Of the 16 women initially approached, 10 participated in the study. For these 10 women, an appointment for an interview was arranged by one of the two researchers. All of

the interviews were conducted between four and six weeks after birth.

Conduct of the study

The standard ethical principles (Beauchamp and Childress, 2001) guided the study. Permission to undertake the study was obtained from the department head at the obstetrics and gynaecology department at the hospital concerned, and approval was gained from the Research Ethics Committee at University West.

A signed consent form was obtained from each woman. The participants were assured that all information would be treated confidentially. The women chose where the interview should take place, either in their homes or at the hospital. Six interviews were performed at the women's homes and four at the hospital.

The interviews started with the initial questions, 'Could you start to tell me from the point when you got to know you were pregnant?' and 'Could you tell me about your experience of encounters with and treatment by the caregivers during the pregnancy and childbirth?' The women were encouraged to describe their experiences as openly and freely as possible. Follow-up questions such as 'what do you mean?' or 'can you tell me more?' were also posed. After the interviews, the women were given time for reflection on the feelings and subjects they felt were important for further discussion. The interviews lasted between 35 and 90 minutes. In this report, all the women were given fictional names in alphabetical order from A to J.

Data analysis

In the data analysis, the phenomenological method developed by Karlsson (1995) was adopted. It consists of five steps. In the first step, and in order to get a sense of the whole, the tape-recorded interviews were listened to and several readings of the transcriptions were made. The second step involved identifying meaning units (MU) in the text. The division into MUs did not follow common grammatical rules, but was made where a shift in a meaning sense could be discerned. In the third step, the analysis in a proper sense took place and the inherent meaning of being obese and pregnant was traced out by transforming each MU with its spoken language into the written language of the researchers. The second and third steps of the analysis are illustrated in Table 1.

In the fourth step, the transformed MUs were synthesised into synopses of individual structures, one for each participant. These represented the subjective descriptions of how it is to be obese and pregnant in encounters with caregivers. The 10 individual structures were, in the fifth and final step, synthesised into one

Table 1

Illustration of the analysis in the empirical phenomenological psychological method steps 2 and 3 from the interview with Fanny.

Example of meaning units	Transformed meaning units
Of course, if somebody says something, it is not funny to hear. But at the same time, one's aware of it.	Fanny does not think it is fun to hear comments about her obesity. But at the same time, she means that she should not be sad about the comments because she is aware that she is obese.
If you seek [medical care] for tonsillitis, you do not have to hear that you are obese. One already knows that.	Fanny sought medical care because of tonsillitis and was told that she was obese, which she thinks is irrelevant and unnecessary to hear from anyone because she knows she is obese.

essential meaning structure, which demonstrates the objective side of the phenomenon studied and the invariant meaning. Finally, themes of the essential meaning structure were described in more detail.

Findings

Participants

Ten women between 24 and 37 years of age participated in the study. At the first visit to the maternity care centres, they had a BMI between 34 and 50. Three of the women gave birth to their first child, whilst the remainder had given birth before. Two women were delivered by caesarean section and eight gave birth vaginally. The participants came from different parts of the region and attended seven maternal care clinics.

One of the 10 subjective synopses describes an individual structure (step 4). The essential meaning structure (step 5) describes the objective and invariant meaning of the experiences perceived by all 10 participants. In the themes, the women's experiences are described in greater depth and verified with quotations.

An individual structure—a subjective description

Irma was very sensitive about comments concerning her obesity, which naturally aggravated during pregnancy. She disliked weighing herself and she did not want to talk about her weight, or even see the figures on the scale. She did not want her husband to know her weight either. Irma felt that the midwife at the maternal care clinic listened to her. Irma thought that the midwife was perceptive and nice because she was affirming.

Once, when Irma had to do a physical examination, she was treated badly and talked to in a sarcastic and negative manner. Irma felt that she was sneered at when she had to change position and that larger equipment was needed because she was obese and therefore difficult to examine. Irma left the place in tears and felt upset. At the same time, she felt happy that her baby was healthy.

She was more worried about the humiliating treatment she might receive than about how the baby was doing; something that was noted in her file. At a later visit Irma was told about this note, but otherwise ignored. She was told 'notwithstanding this, the fact is that you really are obese'. As she was afraid of not getting adequate care, she did not dare to question this humiliating treatment.

At the delivery ward, she was initially met with a smile and kindness. She felt respected, which made her feel calm and secure. However, because she was nervous that someone would talk about her weight, Irma told her husband to support her if that were to happen. She was happy that the caregivers were kind and understood that she felt uncomfortable undressing and concealed her body when changing clothes. Afterwards, Irma felt happy in proving it had been possible to give birth without complications, even though she was obese.

The essential meaning structure—the objective description

The meaning of being both obese and pregnant is living with a constant awareness of the body, and its constant exposure to the close observation and scrutiny of others. It involves negative emotions and experiences of discomfort. Feelings of discomfort increase as a result of humiliating treatment, whilst affirmative encounters alleviate discomfort and provide a sense of wellbeing.

Being constantly aware of the obese pregnant body

Disregarding how the women were treated by caregivers, they were constantly aware of their obese body, although overweight was seen as a temporary state. The women were aware that they were bigger than others. Concurrent with their wish to weigh less in the future, they were, at the same time, hesitant about being capable of losing weight. The body was experienced as an 'it' and just being a 'carrier' for the baby. Physical problems, pain and discomfort due to the heavy body hindered the women from being active and mobile. Examinations performed on the body were not perceived as performed on themselves, but as examinations of the pregnancy and how the baby was growing. The pregnancy lived its own life in the body and nature took care of it, without the possibility of influencing the process. Still, being pregnant was the only time it was acceptable to have, and to reveal, a big stomach.

Constant awareness was described by Eva as:

... hopefully no one is nearby, when I have to tell her how much I weighed, usch. One felt so embarrassed in one way or another, yes. (Eva)

Being exposed and scrutinised

The women had a prevailing wish that weight should not be the focus for caregivers. To be judged by their body size created feelings of alienation, and not being seen like other women. Examinations were experienced as frustrating, and efforts were made to help by lifting up the stomach. Thoughts that clothes, and equipment used for examinations, would not be big enough were worrying and frustrating. All weight controls were perceived as uncomfortable. Feelings of not wanting partners or others to know one's weight or to reveal clothing sizes evoked feelings of shame, embarrassment and frustration. To be obese and to be forced to reveal one's body was embarrassing:

It was this thing; she asked if I wanted to take a bath or not. And, I didn't. Of course not, because I didn't want to reveal myself in front of my boyfriend. I'm very sensitive. And I knew that I had to do it [show her body] because the room was so big, there. But then she was like, 'do that [take a bath], it feels good'. But I didn't tell her why I didn't. (Jenny)

Negative emotions and experiences of discomfort

The women felt guilt due to their obesity that implied concern during pregnancy and childbirth, both for their own life and the baby's, along with fear of death and not being able to be there for the child/children. Concerns about health could also include getting incorrect dosages of drugs, thrombosis or going through a caesarean section. Gaining a lot of weight during pregnancy and the fear of not being able to lose it subsequently was troubling and evoked feelings of sorrow and anger. Avoiding weight gains during pregnancy seemed almost impossible, and brought on feelings of resignation and a sense of 'that's how things are right now'. Low self-esteem was considered to be a reason for anticipating different treatment compared with smaller-sized persons. Talking and joking about their size helped to create relief in uncomfortable and nervous situations. In order to alleviate discomfort, the women were permanently defensive and constantly afraid that someone would comment their weight.

When caregivers left the room and were out of earshot, the women felt suspicious about what the caregivers thought and said about them, for example how big and difficult to examine they were. Feelings of resignation and a sense of not wanting to jeopardise the situation and risk receiving inadequate care by confronting the caregivers to state their opinions were experienced, as was a fear of showing emotions like sadness, anger and disappointment. Anxiety about hurting a midwife's feelings

prevented the women from changing to another midwife, even if the woman felt insecure, not recognised or was treated badly. As a response to the caregiver's behaviour, the women explained how they often kept silent and did not state their opinion or how they 'stayed in their shell'. Experiences of trying to ignore the bad treatment and an acceptance that caregivers might have a lot of things to do were common coping strategies:

...if I had had strength I would have changed midwife. That I would have done. I didn't have the strength. Because the only thing I felt was, oh God just let the days pass so that he would come out. Being forced to feel ill and then having to go to a midwife who is nonchalant. (Helena)

Humiliating treatment

Being treated in an offensive manner exacerbated feelings of shame and guilt. Hurt feelings and sadness were experienced due to being difficult to examine. Feelings of outrage have followed throughout their obese lives. The advice and comments of others did not help in losing weight but, on the contrary, triggered increased eating. Experiences of being advised not to become pregnant at all evoked both anger and guilt. When seeking care or having to do a pregnancy check, the women had perceptions that caregivers were rude, angry, moody, abrupt and bitter. This enhanced the women's feeling of being less worthy than other women who were not obese. Visits to hospital often involved being accompanied by a trustworthy person as a means of support. Not being treated seriously or not being responded to increased feelings of frustration. These negative feelings were evoked when the women were not recognised or respected as other pregnant women. Not being involved in their care or being disrespected about birth plans evoked feelings of being ignored. Going through different painful examinations evoked feelings of being badly treated. Scepticism against the caregivers could arise when the latter hesitated to believe the obese women's experiences of body signs/contractions, baby's kicks and position. Helplessness and disappointment were experienced in encounters with caregivers because they did not focus on the women's needs. A sense of not being understood arose when caregivers required postures that were almost impossible to achieve due to the obese pregnant body. Whenever a caregiver's approach intruded on integrity and private life, feelings of being under suspicion were experienced:

...so she thinks that she can talk to me whichever way she wants and I feel that she damn well can't. Because if she is a 'fat-hater', as I call it, she has to keep that to herself. (Doris)

Affirming encounters

Treatment that relieved discomfort accomplished feelings of security and affirmation. When caregivers were considerate and interested, the feeling of discomfort was reduced and situations became relaxed. Feelings of joy were described when being encouraged and after having accomplished individual goals, for example, quitting smoking or minimising weight gains. Being seen behind the fat and listened to evoked feelings of being treated just like anyone else, leading to surprise and joy. A caregiver's interest and intimacy evoked feelings of being special and important. The experience of participation in their own care decreased discomfort.

Seeing smile on the caregiver's lips and laughing together was encouraging and created affinity. Embarrassing and uncomfortable situations became relaxed when caregivers were humorous. A joyful and open atmosphere eased tensions and made it easier to relax. Encouragement increased feelings of joy and of being proud to be pregnant and able to give birth. Experiencing

support from caregivers gave strength and power for self-assertion during pregnancy and birth:

Since you were actually treated like anyone else. But that's not the thought you have. (Bea)

Discussion

This study was conducted with 10 obese women, and their experiences may differ in some unknown way compared with other obese pregnant women. The findings here may relate to all women's experiences of encounters with caregivers during pregnancy and childbirth, and not just obese women's experiences. However, this study supports that obese pregnant women are at risk of feeling discriminated against in receiving bad treatment, which may lead to increased negative emotions and discomfort. This assertion is supported by [Hunt and Symonds \(1995\)](#), who described that women are morally evaluated by midwives. For example, they found that obese women were judged by their body size and that midwives made stereotypical comments both in the women's presence and out of earshot ([Hunt and Symonds, 1995](#)). Furthermore, [Brown et al. \(2006\)](#) state that obesity is highly visible, which increases the obese person's own feelings of being stigmatised and anticipating negative stereotyped treatment ([Puhl and Brownell, 2001](#); [Brown et al., 2006](#)).

Reflections on the performance of the study

Before the interviews, the authors we discussed their pre-conceptions and attitudes about obesity and made an effort to put these aside during the interviews. In line with [Karlsson's criteria \(1995\)](#), the authors strived to stay as open and non-judgemental as possible, both in the interview situations and in the analysis. Furthermore, validity or trustworthiness depends on how the implementation of the horizontal and vertical consistency of the interpretations is achieved ([Karlsson, 1995](#)). Horizontal consistency was assured by ensuring that the meanings expressed in the raw data were not changed during the stages of the analysis, and that the interpretation fits the meaning discovered in the transcribed data. In a phenomenological study, all theories should be set aside ([Karlsson, 1995](#)). To ensure this, all stages of the analysis were carefully scrutinised by the third author. Vertical consistency can, to a certain degree, be assured in this presentation through how well the essential meaning can be identified in the described themes and how quotations from the raw data fit these descriptions. However, the quality of a phenomenological description should not be discussed in terms of being true or false, rather as being more or less meaningful. The description of the essential meaning structure in this study is one possible way of considering this phenomenon.

Reflections over the findings

The women saw their obesity as a temporary state that they themselves could, and intended to, do something about in the future. They expressed an awareness of their obesity and that the responsibility for the obesity was their own. This is in accordance with what [Brown et al. \(2006\)](#) described about obese patients' feelings of ambivalence about seeking help and their own stigmatised view on obesity, meaning that weight loss is controlled by the individual and if not successful is due to laziness and lack of self-discipline ([Brown, 2006](#)). Thus they did not want to hear comments about it.

Even though the authors did not focus on risks, all the women in this study talked about risks with obesity when pregnant, but

in different ways. The women had varying knowledge about risks of obesity during pregnancy and childbirth. Some of them had great concerns, but some argued that there are as many risks for any woman. Obesity is considered as a multifactorial disease that develops from genetic, metabolic, social, behavioural and cultural factors (Astrup et al., 2004; Rosmund, 2004; WHO, 2006). In this study, the women did not, however, see their obesity as a disease. From a contrary perspective, caregivers tend to view obesity as a health hazard for both the woman and the fetus (Brown, 2006; Krishnamoorthy et al., 2006), and therefore desire close scrutiny. The obese women perceived that they were seen as high-risk patients or, in other words, as statistics. A collision in perspectives on obesity during pregnancy and childbirth can be discerned. This could be tantamount to what Werner and Malterud (2003) found in their study about women with chronic muscular pain. To be believed, understood and taken seriously in medical consultations, the women not only had to struggle to assert their credibility, but also struggled to preserve their self-esteem or dignity as both patients and women (Werner and Malterud, 2003). Even though the women in this study had a stigmatised view of themselves, their wish was to be seen and treated as pregnant and birthing women. The women had similar feelings of shame, blame, responsibility and stigmatisation as Werner and Malterud (2003) describe among persons with chronic illnesses. However, whereas the chronically ill strive to legitimise their illness, to achieve the role as someone who is sick, the obese women in the current study strived to be seen as healthy. Hunt and Symonds (1995) explain how birthing women are stripped of their identity and autonomy when entering the hospital. The women adopt a sick role and the midwives take control over the situation. Labour has been an undesirable condition where the birth is the cure. Considering these aspects, it is noticeably even more difficult for obese birthing women to be seen as autonomous individuals with their own wishes.

The women's experience of the body as an 'it' may be the result of self-objectification of their bodies. According to Merleau-Ponty (1995), the consciousness and the body form a single unit, and the self and the body are experienced as a whole; 'I am my body'. Furthermore, we have access to the world through our bodies; 'we are to the world as bodies' (Merleau-Ponty, 1995). In this study, the women described an experience of separation between the self and their body. Also, the caregivers tend to focus on the body and risks, but not on the woman as a whole. When we meet people who are obese, it is unavoidable not to notice the body mass. The women in this study described that they felt exposed and vulnerable, which may be further aggravated by the caregiver's attitudes. When caring for other people, the relation between the patient and the caregiver is central. Regardless of body size, we need to see and meet the other in an ethical way, as a subject to a subject (Lévinas, 1992). Parse (1998) argues for being 'true present' with the other. However, the possibility to understand a person's life-world experience could be impeded due to prejudice. Therefore, it is essential for caregivers to question and reflect upon one's their prejudices about the phenomenon, here excess weight and obesity. Halldórsdóttir (1999) argues that a caregiver also needs to analyse her/his own vulnerability, suffering and shadows in order to be able to help another human being to health.

The women's constant awareness of their obesity was something they could not hide; it was permanently scrutinised by others and created feelings of shame. According to Ericsson (1994), experiences of shame make individuals more sensitive about others' views of them. Obese women's view of themselves as not being attractive are verified by Levine (2000) and Pine (2001) who state that there is a strong preference for thinner body shape in the cultures and mass media of Western societies. People

search for similarities with others in order to avoid feelings of alienation (Cramer and Steinwert, 1998; Strandmark, 2004). Feelings and sense-experiences increase when pregnant and this is of central importance when giving care support (Haldorsdottir and Karlsdottir, 1996b; Broden, 2004).

Viewed from a phenomenological perspective, we live in time which is more than measured clock-time. Experiences perceived in the past and thoughts about future experiences coalesce into present time (Merleau-Ponty, 1995). Among obese women, this means that earlier experiences of shame and thoughts about anticipated embarrassing experiences increase the shame-experience in the present.

The experience of humiliation increased the obese women's feeling of discomfort and negative emotions. Feelings of negative experiences with caregivers affect wellbeing for pregnant women (Berg et al., 1996; Halldórsdóttir and Karlsdóttir, 1996a; Lundgren, 2004; Nilsson and Lundgren, 2007). In this study, the women described their defence mechanisms when treated badly; they 'stayed in their shell' or got angry. However, they did not display anger or assert their rights to the caregivers because they were afraid of the conflicts and the consequences it might have for their care (Halldórsdóttir and Karlsdóttir, 1996a; Edwards, 2005). Patients do not question the authoritative voice of medicine and they hesitate to express their own views and needs, because they are dependent and they ascribe the professionals to know best (Edwards, 2000). Moreover, obese pregnant women, in common with women with eating disorders (Stapleton, 2007), did not disclose their specific concerns or problems to their midwives because they did not think that the midwives had the appropriate knowledge or interest (Stapleton, 2007). Since all care encounters involve relationships of power, caregivers need to understand and recognise that they have power (Fossum, 2003). The asymmetries in care relationships are inevitable since one seeks help from another and one gives help to another (Fredriksson and Eriksson, 2003).

Experiences of insult, objectification and neglect by caregivers create suffering (Dahlberg, 2002). Suffering arises from health-care relationships and the responsibility is always the caregivers. Caregivers unconsciously cause suffering related to care due to a paucity of reflection and deficient knowledge about human suffering (Ericsson, 1994; Halldórsdóttir, 1999; Dahlberg, 2002).

Factors that alleviated discomfort and negative emotions were when the women were affirmed, recognised and taken seriously. Rafael-Leff (1991) describes how women perceive the midwife as a mediator between herself and her baby. The caregivers who are present through pregnancy and childbirth hold the key to the unknown, to what happens in the woman's body and to the baby (Rafael-Leff, 1991). Women have great respect for professional caregivers (Rafael-Leff, 1991; Edwards, 2000). The support of the midwife is essential for all women's experiences of pregnancy and childbirth (Haldorsdottir and Karlsdottir, 1996b; Edwards, 2005; Lundgren, 2005), and is particularly important for obese women because of their expectations of not being treated like others.

The hands of a midwife are her tools. Thus, it is natural for a midwife to use her hands when giving care and being with a pregnant and birthing woman. Consequently, it is important that midwives are aware that touching the fat body could awaken discomfort for obese women, if the act is not experienced by the women as affirmative. Midwives and physicians have knowledge about their responsibility for promoting health, but face difficulties in talking about obesity and its risks due to unwillingness to worry women during pregnancy, since pregnant women naturally worry about the baby's life. Some women were dissatisfied when the midwife focused overly on their weight and attendant risks during pregnancy, whilst others desired such discussions. More research is needed about attitudes and approaches of midwives

and physicians' when caring for obese pregnant women, and whether the birth outcome for obese women follows the expectations of caregivers.

Conclusion

Obese pregnant women are a vulnerable group because obesity is highly visible. Caregivers tend to focus on providing care to obese patients somatically, but are additionally in need of knowledge about care from the woman's point of view. Many obese women have negative experiences of health care that they have to overcome. Thus, a respectful and dignified treatment is of the utmost importance for their wellbeing and quality of life. It is necessary to individualise care for obese pregnant women, which involves taking time to give the women an opportunity to tell their own story. Caregivers have to promote health but it has to be done honestly and respectfully. In giving substantial and practical guidance, caregivers might have to search for help from other professions in and outside the health-care boundaries. In order to avoid judgemental attitudes and causing increased suffering for obese pregnant women, midwives and physicians need to be conscious about, reflect upon and verbalise their own attitudes and power.

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