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Abstract

Introduction:
Excessive gestational weight gain, regardless of initial BMI, is associated with perinatal risks for both mother and offspring and contributes to obesity in women. Studies report that healthcare professionals find it difficult to communicate about weight and pregnant women perceive healthcare professionals as unconcerned, leaving many women uninformed about weight recommendations and risks. We aimed to explore how midwives approach communication about gestational weight gain recommendations, and to characterize communication barriers and facilitators.

Methods:
Seventeen midwives from different areas in Sweden were interviewed by a therapist using semi-structured interviews. Interviews were transcribed verbatim and analysed by three researchers using latent content analysis. Recurrent themes were identified and formulated.

Results:
The main theme identified in the latent part of the analysis was “Midwives use avoidant behaviours to cope with fear of inflicting worries, shame or feelings of guilt in pregnant women”. Avoidant behaviours include: adjusting weight recommendations, toning down risks and avoid talking about weight. Subthemes identified were I) Conflicting responsibilities in midwives’ professional identity II) Perceived deficiencies in the working situation.

Conclusion:
Midwives’ empathy and awareness of weight stigma strongly affects communication about weight with pregnant women, and midwives’ use of avoidant behaviours constitutes salient information barriers. More research is needed on whether gestational weight guidelines and weighing routines for all women, resources for extra visits, training in specific communication skills and backup access to other professions can facilitate for midwives to initiate and communicate about healthy gestational weight development, enabling more pregnant women to make well-informed lifestyle choices.
Introduction

Excessive gestational weight gain, defined as weight gain exceeding the Institute of Medicines’ guidelines from 2009 (Rasmussen and Yaktine, 2009), has been found to contribute substantially to postpartum weight retention and obesity in women (Amorim et al., 2007; Mannan et al., 2013; Nehring et al., 2011; Phillips et al., 2014). A growing amount of studies also show that regardless of initial Body Mass Index (BMI), excessive gestational weight gain increases the risk for gestational diabetes, pre-eclampsia, large for gestational age babies and caesarean delivery (Cedergren, 2006).

The recommended range for pregnancy weight gain, based on initial BMI, is 11-16 kg for normal weight (WHO definition), 7-11 kg for overweight and 5-9 kg for women with obesity (Rasmussen and Yaktine, 2009). The recommendations are based on observational studies and indicate the optimal gestational weight gain span to balance the risk of having a large for gestational age (LGA) or a small for gestational age (SGA) baby.

Midwives play an important and versatile role in promoting healthy behaviours in women during pregnancy, and with more than 47-70% of pregnant women exceeding weight gain recommendations (Akgun et al., 2017; Brownfoot et al., 2016a; Johnson et al., 2013) there is increased interest in helping women limit their gestational weight gain. However, among pregnant women who participate in intervention programs, about 40-60% still gain excessively (Brownfoot et al., 2016a; Lindholm et al., 2010; Phelan et al., 2011), indicating that there is room for improvement. Also, studies report that due to the sensitivity of the topic, healthcare professionals find it difficult to communicate about weight (Anderson et al., 2015; Duthie et al., 2013; Hasted et al., 2016; Heslehurst et al., 2013; Willcox et al., 2012), and correspondingly pregnant women perceive healthcare professionals as unconcerned when they tone down risks with excessive gestational weight gain or avoid addressing the issue at all (Callaway et al., 2009; Christenson et al., 2016; Duthie et al., 2013).

This is unfortunate since women who are aware of their own BMI and individual weight gain recommendations are more likely to gain adequate gestational weight (Shulman and Kottke, 2016; Whitaker et al., 2016). In some previous studies, pregnant women were positive to healthcare professionals bringing up weight (Atkinson et al., 2016; Dinsdale et al., 2016) and to being weighed (Brownfoot et al., 2016b; Heslehurst et al., 2017), while other studies showed that women with obesity wished that weight should not be in focus for caregivers, and perceived weight controls as uncomfortable (Nyman et al., 2010). These findings suggest a potential communication problem that is largely unexplored and may leave pregnant women unaware of risks with excessive gestational weight gain and thereby less able to make well-informed lifestyle choices (Christenson et al., 2016).

Aims

We aimed to explore how midwives approach communication about gestational weight recommendations with women of BMI ≥18.5, and to characterize communication barriers and facilitators and thereby identify areas where improvements of interventions can be made.
Methods

Study Design
To explore and obtain in-depth data of a complex research area where knowledge was limited, we chose qualitative methodology, utilising semi-structured interviews with consenting midwives. Interviews were carried out by the first author, a cognitive therapist with prior experience from study interviews.

Antenatal care in Sweden
Standard care for pregnant women in Sweden include about ten visits to a midwife at an antenatal clinic (Olovsson, 2016). If the pregnancy is considered uncomplicated there is no doctor’s visit involved. The first visits around gestational week 8-12 are followed by an ultrasound in week 18-20 and then regular follow-up visits from week 25 until birth.

There is a national agreement in maternal health care to promote healthy gestational weight gain based on IOM guidelines. The actual implementation of the agreement varies between regions and antenatal clinics. In general, BMI is calculated at the first visit and additional weight is collected at 24 and 35 weeks. Some antenatal clinics have locally designed intervention programs, aimed to limit excessive gestational weight gain, focusing mainly on women who start their pregnancy with BMI ≥30 kg/m².

Many Swedish midwives have received some form of course in Motivational interviewing (MI). MI contains several components that can be used for conversations about weight, such as asking what the woman already knows about the subject, how she feels about her weight and asking for permission to provide further information.

Study participants and recruitment
To retrieve as many different angles and experiences as possible of the area of research interest, recruitment was purposeful as we wanted as diverse a sample as possible regarding working experience, year of graduation, experience of participating in a weight intervention program, geographical location and socio-demographic characteristics of the pregnant population where the antenatal clinic is situated.

Seventeen midwives, with experience of working with women during pregnancy, where recruited between November 2016 and February 2017 via emails and phone calls to antenatal clinics. The first author contacted the head of each clinic and they in turn asked their midwives if they wanted to participate after having been informed about the purpose of the study. Participants came from 12 different antenatal clinics from different parts of Sweden and from areas that varied in socio-demographic structure. Three clinics that were approached at the beginning of the study, declined participation due to lack of time. Nine of the clinics had been previously engaged in intervention programs.

All participants received oral and written information about the study purpose and procedure, and provided written informed consent. Since no patients participated in the
study, no ethics approval was needed according to The Stockholm Research Ethics Vetting Boards decision nr: 2016/1278-31/5.

Data collection
A semi-structured interview guide was used to certify all pre-planned subject areas were covered (midwives’ awareness of weight gain recommendations, their approach to promoting it and perceived hinders), while also allowing midwives to speak freely about whatever topic they associated with the subject:

- Tell me what you know about the association between weight gain and health during pregnancy?
- Where did you get your weight related knowledge from?
- What are your experiences of communicating about gestational weight gain?
- What are your experiences of weighing pregnant women?
- What do you do if you notice an unhealthy weight development?
- What do you think is the reason for excessive gestational weight gain?
- What do you think promotes healthy weight development during and after pregnancy?
- What are your beliefs and experiences around breastfeeding and weight change?
- What do you think (if anything) could help you improve your ability to promote healthy weight development in pregnant women?

To go deeper and clarify any uncertainties, the first author probed with more questions when necessary and midwives were encouraged to tell us about any factors they associated with the research topic. The midwife chose a convenient location, which was either in their clinic, at a hotel, or via Video call. The interviews comprised 10 face-to-face interviews and 7 video calls and lasted between 30 and 46 minutes, mean and median: 37 minutes. Interviews were audio-recorded and field notes were taken during the meeting.

After the interviews had been transcribed verbatim, the recordings were erased and participants were emailed a copy of the transcript to be able to correct or complement their statements. Three participants wanted to add or clarify their transcripts, one to provide information about the weight range of their scales, one to add information about the contents of their own website and one to specify the number of pregnant women she had met that had undergone bariatric surgery.

Data was analysed continuously and midwives were recruited and interviewed until no new data or topics occurred in the last three interviews and it was decided between the researchers that the data set was saturated and the diversity of the sample was sufficient.

Data analysis
The transcribed interviews where depersonalized and latent content analysis was made by reading through the material several times while highlighting all passages relevant to the research questions. Longer passages were condensed to shorter sentences, labelled with a descriptive code and clustered into categories.
The coding, clustering and the overall content was thoroughly scrutinized on several occasions between three researchers (AC, EJ, EH) and after extensive discussions two sub-themes emerged and one main theme was formulated. The quotes used in the result section were translated from Swedish to English by the author and then checked by three English speaking peers.

Findings

Participants’ characteristics

Table 1. Characteristics of participants (n=17)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year of midwifery degree</td>
<td>1982-2015</td>
</tr>
<tr>
<td></td>
<td>Median 2001</td>
</tr>
<tr>
<td>Years of working experience in an antenatal clinic</td>
<td>Mean 12.5</td>
</tr>
<tr>
<td></td>
<td>Median 12 (1-30)</td>
</tr>
<tr>
<td>Number of midwives who have received no education about risks and recommendations regarding weight development</td>
<td>9 (53%)</td>
</tr>
<tr>
<td>Number of midwives who have received extensive, specific education about risks and recommendations regarding weight development, obesity, diet and physical activity</td>
<td>2 (12%)</td>
</tr>
<tr>
<td>Number of midwives who have received lectures on diet</td>
<td>6 (35%)</td>
</tr>
<tr>
<td>Number of midwives who have received some kind of MI-course</td>
<td>15 (88%)</td>
</tr>
</tbody>
</table>

Emerged themes

One main theme and two sub-themes emerged (Table 2). The main theme identified in the latent part of the analysis is a product of the sub-themes and describes a phenomenon that affects midwives’ approach and perceived ability to promote healthy gestational weight development.

Table 2. Main theme with underlying sub-themes and categories

<table>
<thead>
<tr>
<th>Main theme</th>
<th>Midwives use avoidant behaviours to cope with fear of inflicting worries, shame or feelings of guilt in pregnant women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-themes</td>
<td>Conflicting responsibilities in midwives’ professional identity</td>
</tr>
<tr>
<td>Categories</td>
<td>Perceived deficiencies in the working situation</td>
</tr>
<tr>
<td></td>
<td>Promote healthy gestational weight gain</td>
</tr>
<tr>
<td></td>
<td>Be empathic and consider weight stigma</td>
</tr>
<tr>
<td></td>
<td>Keep the woman calm and at ease</td>
</tr>
<tr>
<td></td>
<td>Lack of specific competence (communication skills and knowledge of nutrition, physical activity and weight recommendations)</td>
</tr>
<tr>
<td></td>
<td>Lack of resources and support (time, written material, guidelines, weighing routines, access to other)</td>
</tr>
</tbody>
</table>
Midwives use avoidant behaviours to cope with fear of inflicting worries, shame or feelings of guilt in pregnant women. (main theme)

Midwives disclosed different strategies, such as adjust weight recommendations, tone down risks or avoid talking about weight, to deal with the dilemma of feeling responsible for bringing up weight, while considering weight stigma and keeping the pregnant woman calm and the relationship between care giver and care taker comfortable. If the recommended dietary advice or weight gain goal was judged to be unrealistic for the woman, midwives adjusted the recommendations (without the woman knowing so) allowing a larger weight gain.

“...so, we kindly listen to what the dieticians have to say but then we do not give that advice to our patients. /.../A: So, there is a discrepancy between what you hear from the dieticians and what information you feel comfortable with passing on to the pregnant women? MW: Yes! And at the same time, the whole situation gives me bad conscience, because they [dieticians] are the professionals, while I am the one who has to face the women in this vulnerable situation. So, I feel I am not pleased at all with how I handle the situation. I tend to adjust my advice ad hoc to the woman in front of me to connect with her and to make things comfortable, because I am the one who will see her for months and we need to have a good relationship and not become enemies. A: So, making the woman feel comfortable is of higher priority than providing her with the precise weight gain advice or the risks? MW: Yes, exactly, that’s it!” (Midwife 8)

Another strategy if a woman was gaining excessively, while trying to limit weight gain, was to provide positive encouragement without mentioning numbers or risks in order not to make the woman feel bad.

“You don’t want her to experience a bad pregnancy, so then I kind of go like “well, just keep up the good work and you are doing the best you can! Because you don’t want them to feel that they hardly want to come here because they feel they have not done well enough.” (Midwife 7)

Sometimes midwives completely avoided the subject if they deemed the woman to be psychologically vulnerable or already under too much pressure, or if the woman seemed to want to avoid the subject herself.

” She comes here and cries over her relationship with her husband. With her, I don’t feel I can really push her to do anything about her excessive weight gain. /.../so in her case I just mention weight briefly because I feel that although it is not good for her to gain so much, she is already dealing with so many other challenges.” (Midwife 11)

“...and some of them prefer to weigh themselves at home and then they go like “Oh, yeah, my weight, I’ve gained two kilos since last time”, but without saying what they actually
weigh. /…/ Then we don’t talk about it [the weight]. A: So, some of the women seem to want to avoid the subject and then you become compliant and avoid it too? MW: Yes, actually.” (Midwife 3)

All clinics had scales that could weigh up to 150 kg, and some more. To assess weight from reluctant women, midwives emphasized medical reasons to persuade them, and allowed them to keep their eyes shut to stay unaware of their own weight. Using the term BMI instead of kilos was seen as a good way to emphasize the medical incitement for bringing up the subject. Some midwives found it easier to work around the shame scene by using the baby’s health as focus and spoke from the baby’s perspective, thus distracting the women from her own health perspective.

“Because I don’t want to point fingers and say:-Hold on a minute! Now you’re eating too much!” Instead I tell her that the baby doesn’t like crisps and candy. I use that a lot, saying that the baby wants vitamins and minerals.” (Midwife 7)

Conflicting responsibilities in Midwives’ professional identity
(sub-theme 1)

Promote healthy gestational weight gain
All midwives described a willingness to promote healthy gestational weight gain and it was considered being part of a midwives’ job to calculate BMI at the first visit and to inform women with BMI ≥30 kg/m² about the benefits of limiting gestational weight gain. Local policies differed regarding which women to target with information and in how much weight gain was recommended and very few clinics had specific guidelines for women with BMI <30 kg/m².

“I weigh them every time. I consider it [weighing] important and I mention weight a lot and I think they should come back for the follow-up visit post partum.” (Midwife 1)

“...we also tell the women with normal weight that it is unhealthy to gain too much; that it is heavy to bear, and will be hard to lose and bad for their joints and such...but we focus mainly on women who already have a high BMI when they enter pregnancy.” (Midwife 6)

Participants conveyed that when they assume that normal weight women will have a healthy weight gain, they sometimes find themselves in a problematic scenario later on, when a woman has gained excessively by the next visit and it feels too late to bring up risks and recommendations.

“It is harder with the normal weight [women] who turn up in week 25 and have gained perhaps 15 kg.” (Midwife 3)

Be empathic and consider weight stigma
The awareness of weight stigma pervaded all stories and midwives revealed a deep concern and understanding both about the stigma of being overweight, as well as the shame of being unable to limit one’s weight gain, regardless BMI, and they were aware that severe weight problem may originate from psychological trauma. The shame was mentioned as something
that needed to be considered, especially if the woman was already obese or had gained excessively.

“It is often hard because many women don’t want us to point it [the weight] out or they feel bad or unhappy with their body. I mean, for many women it’s a very delicate matter.” (Midwife 12)

A majority of midwives reasoned that, in comparison, they find it much easier to bring up smoking, alcohol consumption or to ask about domestic violence than to bring up weight.

“The shame is very obvious in some women. They were probably bullied for being fat at school and now they come to me, happy with their pregnancy and then I start talking about their weight. /.../ Oh this shame! If I compare them [the fast weight gainers] to the heavy smokers who do not quit smoking, there can be more aggressiveness if you push them [smokers] too hard, but not with the overweight women. Being fat seems to be more shameful.” (Midwife 6)

**Keep the woman calm and at ease**

All midwives emphasized the importance of keeping the pregnant woman calm and the relationship between caregiver and caretaker comfortable in order not to put her off attending her regular visits.

“All these risk factors, if you bring them up in the wrong fashion the woman may shut down and completely refuse to cooperate. So, the women who are most at risk are also the ones you need to approach with most care.” (Midwife 8)

The dilemma of trying to fuse the different responsibilities was frequently brought up and all but two midwives said they found it hard to accomplish the required balancing act.

” You try to mention that excessive weight may complicate childbirth, but you don’t want to worry them enough for them to choose a caesarean instead, because that is harder to perform on overweight women.” (Midwife 2)

**Perceived deficiencies in the working situation** (sub-theme 2)

**Lack of specific competence**

Communication skills

A wish for specific training in communication skills to bring up weight and to handle psychological topics behind emotional eating and obesity, were recurrently brought up as a request. All but two midwives had received education in Motivational Interviewing (MI), yet only two midwives expressed that they felt completely confident, while the remaining fifteen midwives expressed various degrees of discomfort about bringing up weight, especially if the woman was already overweight or obese. More confidence was found in midwives with longer working experience or who had received regular supervision with a counselor for additional advice in difficult cases.
“I have taken a course in MI and that has been helpful. /.../ But I would probably need more education in how you actually practically use it in the conversation. /.../ Yes, actually practicing how to have that conversation! How you bring it [the weight] up in a good way that motivates lifestyle change.” (Midwife 15)

Weight related knowledge
In general, midwives were aware of the association between excessive gestational weight gain in women with high BMI, and the increased risk for gestational diabetes, high blood pressure, pre-eclampsia, having a large for gestational age baby or emergency caesarean. Obesity-related risks for the infant, like stillbirth, were only mentioned spontaneously by a few. Some midwives expressed having no previous knowledge of risks with excessive gestational weight gain in women of normal BMI, and very few felt up-to-date regarding nutritional advice during pregnancy. Current dietary advice was often perceived as confusing and some said they disagreed with the advice taught by dieticians. Out of 17 midwives, 8 had received education to various extents about gestational weight gain recommendations or obesity and 15 midwives expressed a need for specific education about healthy weight gain.

” I think it would be good for us [midwives] if we could have guidelines and instructions on what are good and what to recommend. /.../ The weight gain range is kind of arbitrary and I think we give different advice on diet and weight gain. (Midwife 4)

Lack of resources and support

Time
The desire to have more time available for discussions about weight was commonly brought up during the interviews. Many issues need to be addressed during the first regular midwife visits, including assessment of medical history, social situation, antenatal tests, information about procedures etc. and many midwives find they have little time to go deeper into discussions about eating habits and healthy weight gain. It also affected their willingness to probe with questions about underlying factors to excessive weight gain, fearing they may bring painful memories to the surface or induce feelings they would be unable to deal with, both due to lack of time and lack of support from other professions.

“Time is a very important factor because we have such a huge amount of other stuff that we’re supposed to do at the same time. The visits are pretty short and you’re supposed to ask about this and that and there is a lot of screening of medical issues and of domestic violence, tobacco and psychological health, and everything is very important but you have to squeeze it in to a very short amount of time.” (Midwife 12)

Guidelines and routines
The lack of written detailed guidelines and routines was brought up as an explanation among midwives for feeling reluctant to bring up weight. Other participants confirmed that having a policy to refer to, and weighing everybody, made it less stigmatizing and facilitated talking about weight.
“A: So, the fact that you feel it [weight] is a sensitive topic and may be hard and uncomfortable to talk about, how does this affect your communication with these women? 

MW: What happens is that it does not [happen] [laughs embarrassed] ... it is kind of hard to find a way to bring it up that feels natural. Sometimes you can hide behind the policy that if you have a BMI over 30 they are supposed to do an oral glucose tolerant test. /.../ Having a policy somehow makes it easier to raise the subject. It is harder if their BMI is 28, which in itself is an overweight but it does not... I just cannot hide behind a routine. That makes it harder to bring it [weight] up.” (Midwife 15)

Some midwives compared their current reluctance to talk about weight with how it had once been back when they started addressing alcohol consumption or domestic violence, explaining that those topics had become much easier to bring up due to the profound work done to educate everyone, making it a routine and using written guidance as well as having resources to refer women to professional help if needed.

“I think it is really hard [to talk about weight]. And I used to think that about other topics too, like alcohol and domestic violence but that has become much easier since we received a clear tool for how to ask. /.../ Having a written policy has much larger impact then what one may think. You become much braver in your communication when you have a policy to assume.” (Midwife 4)

In areas with inhabitants from many different countries and cultures, midwives thought the lack of brochures and written information material in different languages made it harder to get the message and information through.

Limited access to other professions and support groups

There was a common wish for support groups outside hospital care, where pregnant women could meet up to exercise or to talk about their pregnancy experiences. All midwives claimed to have access to a psychologist or counselor to whom they can refer pregnant women, but in most cases the reason for referral has to be directly connected to pregnancy, such as fear of giving birth or a suspected lack of attachment to the offspring. Other reasons, such as unprocessed traumas or emotional eating would not qualify for a referral.

“So, I think it is really problematic to give information during pregnancy. /.../ When eating is a compensation for something else or you are comforting yourself with food. We have no tools when it comes to psycho-emotional problems. We do have access to a psychologist for pregnancy-related problems but if you have a disordered eating pattern the psychologist dismisses it and says it is not her task because the problem was there before the pregnancy.” (Midwife 8)

Discussion

Main findings

Midwives experience a dilemma of feeling responsible to promote healthy gestational weight gain, while empathy and awareness of weight stigma make them avoid or alter weight gain recommendations out of fear of inflicting shame or guilt feelings in pregnant women. This leaves many pregnant women uninformed about weight gain.
recommendations and risks with exceeding them, and may reduce women’s possibility of making well-informed health choices.

**Weight stigma and avoidant coping strategies**

Weight stigma means labelling someone as lazy, unintelligent, or provide inferior health services based solely on their body weight, and weight discrimination from the public as well as from healthcare professionals has been documented (Mulherin et al., 2013; Puhl and Heuer, 2009). When faced with a possible interpersonal shame scene, people in general handle it by avoidant coping strategies such as: attack self, withdrawal, attack other or avoidance (J. Elison, R. Lennon, 2006). In the results of our study, the combination of empathy and awareness of both weight stigma and the shame of being unable to limit weight gain, strongly affected midwives’ communication in that they wanted to save their patients from feeling uncomfortable and thus avoided the weight subject in different ways. Our results align with other studies where care providers think gestational weight gain is an important but sensitive subject, and providers feel they lack sufficient training in communicating skills and therefore avoid the subject (Foster and Hirst, 2014; Stotland et al., 2010; Willcox et al., 2012). Then again, some caregivers rate their self-efficacy in having these discussions to be high, but they do not undertake the behaviour, at least not according to their patients (Niemasik et al., 2017; Piccinini-Vallis, 2017).

The situation is highly unsatisfactory with more than half of pregnant women in studies reporting to be uninformed about their BMI and weight gain recommendations (Niemasik et al., 2017; Willcox et al., 2015). Awareness is a necessary step in the stages-of-change theory (Boslaugh, 2008) and a key component for lifestyle modification, and knowing ones’ BMI and weight gain recommendations is associated with healthier gestational weight gain (Samura et al., 2016; Shulman and Kottke, 2016; Whitaker et al., 2016). Equally important, women in general, and nulliparous women with obesity in particular, want information and are positive to healthcare professionals bringing up weight and weighing them as a routine (Brownfoot et al., 2016b; Nikolopoulos et al., 2017; Willcox et al., 2015).

**Paternalism or an adequate fear**

With good intentions, midwives sometimes refrain to give crucial medical information to pregnant women. This way midwives are avoiding the discomfort in the moment, but in the long run they are taking on a huge responsibility by not providing women with important medical information.

The question is whether this is the best professional approach in this matter. In each given case, we cannot know whether risk information would have provided the woman with the motivation or incentive she needed to adopt a healthier lifestyle, or whether it would have been perceived as stressful and caused anxiety or reinforced a negative body image. Also, a fear of excessive weight gain could lead to a gestational weight gain below recommendations, which increases the risk of preterm birth or having a small for gestational age baby (Goldstein et al., 2017).

National Institute for Health and Clinical Excellence (NICE) in the UK, do therefore not recommend routine weighing during pregnancy because it may provoke unnecessary anxiety without additional benefit, nor do they have guidelines for gestational weight gain arguing
that even when interventions succeed in limiting gestational weight gain, there is still little evidence of a significant reduction of adverse effects (Kominiarek and Chauhan, 2016).

**Facilitating communication about weight**

The findings of this and similar studies provide insights in problematic barriers in weight communication but also several ideas of possible workarounds that may reduce weight stigma and facilitate intervention.

In comparison, midwives find it less stigmatising and easier to talk about smoking, alcohol consumption or the presence of domestic violence than to talk about weight with someone unable to limit her weight gain, or already obese. One of the reasons may be that with the easier topics they can see the woman as a “victim” and partly blame an “external source” since it is commonly understood that it is difficult and takes more than just knowledge to walk out of an abusive relationship, and that for some, it can be hard to quit smoking or drinking due to addictive components.

It is therefore possible that implementing knowledge from obesity studies that suggests appetite regulation and metabolism are, to a substantial degree, biologically and genetically driven (Ochner et al., 2013), could help lift part of the guilt off of pregnant women’s shoulders and make both women and healthcare professionals less prone to blame the woman’s “poor character”.

Making it a routine to weigh everybody and provide each woman with an individual healthy weight gain span, according to her BMI, could reduce stigma from overweight and obese women and make it easier for midwives to bring up weight. Additionally, important weight gain information would reach the population of normal weight pregnant women who are currently not in focus for intervention programs, while still at risk of excessive gestational weight gain. Written guidelines in different languages may also help communicating the message across language barriers to women not fluent in the local language.

Knowing you have resources to book longer and more frequent appointments when midwives consider it necessary, and improved possibility to refer women to a dietician, physiotherapist or counsellor for more specific professional help could make it easier for midwives to bring up the subject. Midwives wish for the reinstatement of self-help groups outside hospital care is shared by pregnant women who also express a wish to have a non-judgmental supportive group of peers (Christenson et al., 2016; Fieril et al., 2017).

Large studies have revealed a strong relationship between increasing pre-pregnancy BMI and risk of adverse pregnancy events (Kriebs, 2014; Zilberlicht et al., 2016), but full knowledge of this, including the impact of excessive gestational weight in normal weight women, does not seem to have reached the entire midwife population and certainly not women in general. As it stands, the width and depth of weight related knowledge in midwifes is up to local initiatives or the individual midwifes’ own interest. Updated education regarding nutrition, physical activity, weight gain recommendations and obesity could boost midwifes’ self-confidence and increase their inclination to bring up weight (Malta et al., 2016).
Motivational interviewing (MI) is a communication tool that most midwives were familiar with but their perceived insecurity indicates that it may not be enough for this particular topic. Confidence is related to perceived self-efficacy, and more practical training of Motivational interviewing, courses specifically about weight communication, or supervision for difficult cases may be of help.

**Strengths and limitations of the study**

The strengths of the study include the diversity of the sample regarding working experience, year of graduation, experiences of participating in a weight intervention program, geographical location, and socio-demographic characteristics of the population where the antenatal clinics were situated. However, since this is a qualitative study we cannot generalize and assume our findings cover all opinions and experiences of Swedish midwives regarding the research area.

Midwives who chose to participate may be particularly interested in the research area, which could make them less likely to experience communication hinders and more aware of weight stigma than the general midwife population. Still, participants provided us with many examples of barriers as well as suggestions for improvements and our findings align well with similar studies (Furness et al., 2011).

The non-anonymous setting with individual interviews may make participants feel vulnerable and less prone to display their own perceived shortcomings or critic against others, thus one may argue that anonymous questionnaires or focus groups could have supplied more comfort. Our choice was based on our need for the ability to probe with clarifying questions, as well as our interest in each participants’ specific knowledge of weight gain recommendations and risks and we feared that a group setting may make participants adjust their answers to align with the group and that less data could be retrieved from a questionnaire. The content of our interview data also suggests participants felt comfortable enough to disclose their own perceived incompetence in the matter.

The profound expertise of the second author (EJ) regarding qualitative methods increases the trustworthiness of the data analysis.

**Conclusions**

Midwives’ empathy and awareness of weight stigma strongly affects communication about body weight with pregnant women, and midwives’ use of avoidant behaviours constitutes salient information barriers. More research is needed on whether gestational weight guidelines and weighing routines for all women, resources for extra visits, training in specific communication skills and backup access to other professions can facilitate for midwives to initiate and communicate about healthy gestational weight development, enabling more pregnant women to make well-informed lifestyle choices.

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