LIMINAL EMBODIMENT AND THE CHANGING PARENTAL BODY

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ABSTRACT

Liminal Embodiment and the Changing Parental Body

By

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This dissertation sits at the intersection of sociology of the body, parenting, and life course to examine how the role and status of becoming a parent shape individuals' embodiment. Grounded in research highlighting body and embodiment as crucial, yet understudied aspects of social experiences, my study views biological changes as rooted in the social, where symbolic messages shape how parents think and understand their bodies and embodiment. The transition to parenthood serves as a unique lens for analyzing embodiment, as pregnancy, barriers to assisted reproductive technology, and adoption serve as evidence for the intersection of physical and social changes. My study, therefore, aims to fill gaps in existing literature by providing insights into how parents contest, challenge, or accommodate societal messages about their bodies throughout the process of becoming and being a parent. Between May 2021 and June 2022, I conducted 40 interviews with parents who have diverse families, including biological and adopted children. In these interviews, participants recounted their embodied experiences before, during, and after becoming a parent. The results show how embodiment is important to diverse lived experiences and social pathways, over the transition to parenthood. The diverse pathways in the transition to parenthood shed light on varied experiences and hierarchies within social transitions, offering an alternative framing of a universal experience of body size and weight-related stigma. Drawing across these results, I introduce *liminal embodiment*, which merges life

course perspectives with the study of body and embodiment. The concept asserts that bodies are constantly in transition, with embodied experiences influencing social pathways during significant life events, like parenthood. Further, *liminal embodiment* is multidimensional; the transitional nature of the body extends beyond appearance to include performance expectations, particularly in the context of parenthood. These conclusions provide implications for understanding how changes in body size and shape throughout the life course are context-dependent, influenced by social transitions and normative and non-normative pathways. Overall, my project emphasizes the inevitability of bodily changes throughout the life course and advocates for a shift in practices to better support individuals through major life transitions.

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there is more to life than work and supporting me creatively. Here is to the beginning of the next chapter for House Khonach!

PREFACE

I lay down under the blinding white lights of the examination room, my fat body taking up most of the exam table, preparing to remove my long-term birth control, the Nexplanon implant. I have had the implant for nearly 8 years at this point, and in the summer of 2020, my partner and I decided we may try to have children. I lay there, arm extended, with the nurse and OBGYN, the only one I can see at my university's health center. Due to the COVID-19 pandemic, my partner is unable to accompany me as they usually do to support me in our joint reproductive journeys. I'm laying under the blinding white lights as I am asked a third time, the OBGYN now cutting into my arm, if I am sure I do not want to go on a different kind of birth control. I respond again, no, I do not want to be on the hormonal birth control anymore. The OBGYN continues cutting, the nurse blotting away the blood. I am informed of how pregnancies can be complicated by weight, I need to be sure I am using birth control, or at least barrier methods because of the risks associated with pregnancy.

I stare up at the blinding white lights. Trying to focus anywhere else, recognizing that I am at the mercy of the OBGYN as I feel him tug and wiggle out the little implant from my arm. The nurse bandages me up and I am asked again as I regain my seated position, "are you sure you do not want another birth control method?"

The U.S. has a long and sordid history with coercive practices to control family planning, from forced sterilization of women of color, poor women, and women with disabilities, social policies to enforce the use of long-term birth control, queer families from fertility treatments or access to adoption. These histories of forced reproductive and family planning control are also intertwined with rising rates of childfree adults by choice. More and more individuals are choosing to not have children, but family remains a foundational institution.

Uncovering histories of reproductive and family control and the recent Supreme Court decision, Dobbs v. Jackson Women's Health Organization (2022), which effectively overturned Roe v. Wade (1973) and abortion access paints a complicated picture of family planning in the United States. Recent news has been bombarded with headlines about the lack of abortion support across the country and states strip reproductive rights. While I do not want to downplay the importance of the abortion rights and choice, I am also concerned with the framings of reproductive justice, concerning issues of who has the *right* to be a parent and parent the children they have. Reproductive justice to have children becomes overshadowed by choice narratives; not everyone has the ability to choose to have or raise children alongside not all having the choice to obtain an abortion.

Despite barriers to parenting and parenting safely and happily, parents persevere, challenging narratives of who is and is not a "fit" parent in the eyes of medical, government, and social service institutions and organizations. Reproductive Rights and Reproductive Justice movements highlight the nuanced and complicated realities of parenting in the U.S., in a culture which, supposedly, simultaneously values the lives of children and growing families, while denying many from accessing opportunities to have and raise their children.

Much of the research on reproduction and family planning has focused on the right to an abortion or the right to end a pregnancy. Abortion rights were prominent during the second wave of feminism at the height of Civil Rights movement for people of color, queer communities, and women. However, Reproductive Justice is more than the right to an abortion. Reproductive Justice, according to SisterSong, a leading reproductive justice organization led predominately by Black women, is defined as "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable

communities" (2024). Having learned about Reproductive Justice throughout my studies, I became more interested in the myriad of ways people's bodies are controlled in relation to reproduction, including race, gender, sexuality, ability, age, and body size.

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CHAPTER 1

INTRODUCTION

This dissertation examines the intersection of sociology of the body, parenting, and life course through analyzing embodiment over the course of becoming and being a parent. I ask: how does the role and status of becoming a parent impact parents' embodiment? In order to answer this, I use interview methodology to ask participants to recount their parenting journey and how developing the role of parent has impacted their perception and experience of their bodies. I examine participant's responses to how they recall feelings and messages about their bodies before, during, and after becoming a parent.

My work is grounded in research that has identified body and embodiment as an important but often understudied facet of our social experience. The physical body, traditionally viewed through the lens of biology, is often overshadowed by psychology or social interaction. Research on body and embodiment argues that the physical body, including race, size, and physical ability, is the first "sign" in an interaction, displaying messages of our class, gender, sexuality, and health (Shilling 2010; Turner 2008). How we interpret bodies in interaction is informed by symbolic messages associated with the physical body. Biology, therefore, can be interpreted as a social process, where social messages reinforce our assumptions of biological realities. For example, messages about health status and bodies are associated with social statuses like disability, fatness, and race, impact the ways we interact with others and our environment.

I also examine the way embodiment is experienced through different social locations and lived experiences. For example, how might our embodiment change with a new job, a sexual awakening, or education achievement? Gestational parents, or parents who can become pregnant,

demonstrate, in a very short amount of time, the transitional nature of embodiment as their bodies change through pregnancy and how they navigate the conception and gestation processes. Hegemonic idealization about parenting and pregnancy influence messages towards parents who are often made invisible, those who cannot conceive (Bell 2019; Johnson et al. 2020), experience miscarriages (Layne1990), or who adopt their children (Goldberg, Kinkler, and Hines 2011). Once someone becomes a parent, their bodies are no longer their own, put under more intense scrutiny by doctors, family, friends, and even themselves, and used as ways to dictate their deservedness to become a parent (Edvardsson et al. 2001; Ogle, Tyner, Schofield-tomschin 2011; Mulherin et al. 2013.

Parents, especially mothers, are simultaneously valorized and extensively criticized because of their responsibility for raising children (Boero 2009; Chae 2015; Dame-Griff 2016, 2020). Individuals, particularly cisgender women, are expected to have children, and are villainized if they opt to not or struggle to have children. At the same time, the process of becoming a parent, through adoption, conception, or reproductive technologies, reveals hegemonic norms of gender, sexuality, the body, and health. The discrimination toward parents on the margins impacts all parents and has real world consequences, because all parents are expected to perform parenthood within strict parameters, specifically being able to conceive, gestate, and birth a child. Parents who cannot conform to these expectations experience negative outcomes, such as emotional distress, increased stress, and interpersonal conflicts (Maroufizadeh et al. 2015; Palmer-Wackerly and Krieger 2015; Johnson et al. 2017; Klitzman 2017; Langher et al. 2019). Happy parents will produce happy children, and current mechanisms of embodied shame set individuals up with internal insecurities well before they become parents. Overall, I

look at how parents contest, challenge, or accommodate messages about their bodies throughout the process of becoming and being a parent.

My research fills gaps in literature on parenting and embodiment. By bringing embodiment and parenting into focus through the lens of life course, this study contributes to a feminist and sociological understanding of the importance of the body through transitional phases of our life. I aim to expand on this previous literature on parenting by incorporating an analysis beyond the *act* of parenting, such as parenting styles and gendered differences in caregiving, and engage with parents about their embodied experience before and after becoming a parent, focusing on bodily changes beyond pregnancy and birth.

Finally, this dissertation is also an attempt to highlight the ways sizeism, or anti-fat stigma, is a prominent yet vastly understudied aspect of sociology. Statistically, most bodies are categorized as overweight according to the Body Mass Index (BMI) while socially normative bodies are considered thin or athletic. According to the Center for Disease Control and Prevention (CDC 2003), the percentage of adults who are overweight or obese increased from 56 percent in 1994 to 64 percent in 2000. Adults who are categorized as overweight or obese are *statistically* normal, and yet anti-fat discrimination remains prevalent (Puhl and Brownell 2001; Mulherin et al. 2013; Reece 2019; Sabharwal, Reyes, and Stanford 2020; Sherf-Dagan 2022). In what ways does anti-fat stigma impact all parents, regardless of body size? In an age of contentious body positivity, how do parents challenge or conform to body size expectation at a time in their lives when potential weight gain is expected? Overall, my research offers theoretical insight into the ways ideologies such as neoliberalism and healthism influence and control parents and others through embodied expectations.

A Note on Terminology

Throughout this study, I use certain terms that are historically situated and context dependent. Some phrasing may be unfamiliar or uncomfortable to some readers. First, I use the term "fat" to describe bodies which are situated outside normative body sizes, such as those who are perceived as thin or muscular. I use "fat" opposed to terms such as "overweight" or "obesity," in conjunction with fat liberation movements which seek to neutralize the word "fat," using it as a descriptor, similar to thin. Obesity is a medicalized term which stigmatizes fat individuals and has too often been used to downplay or ignore the health conditions of fat people and contribute to racial, classed, and gendered discrimination (Carr and Friedman 2005; Saguy 2013; Strings 2019; Austen, Greenway, and Griffiths 2020; Coffey 2020; Sabharwal et al. 2020). Overweight assumes a normalized weight that someone could be "over", even though one in three Americans are classified as "overweight" (CDC 2023). Both of these terms also use the Body Mass Index (BMI) to establish health guidelines even though the BMI has been shown to be an inaccurate and harmful took for establishing health status of an individual (Hainer and Aldhoon-Hainerova 2013; Tomiyama et al. 2018).

Additionally, I attempt to negotiate language regarding different sizes of fat. Within fat activist spaces, there is a recognition that privilege is nuanced based on size and shape even if one identities as "fat." Gordon (2023), a prominent fat activist, outlines different language for framing different social experiences of size, such as defining fat in four categories: small, mid, large, and super fat. There are contentions in breaking down fat experience into these categories, a critique similar to identity politics which can sever social solidarity (Linda 2021). Many civil rights movements attempted to engage in collective action around specific social locations, such as sexuality, race, and gender but then inadvertently ignored the challenges of those *within* their

movements, such as Black women in the Civil Rights movement, or lesbians in the gay right movements. I want to honor the critiques of weaknesses with social movement spaces and will delineate between different fat experiences when possible without reifying distinct categories.

Second, people of various gender and sexual identities become parents despite laws and policies which often make it more challenging to do so. While the vast majority of my participants are cisgender women who conceived via intercourse with cisgender men, I aim to use inclusive language throughout this text. Rather than saying "having children," which insinuates birth, I instead write "becoming a parent," in an attempt to acknowledge and recognize the multitude of ways individuals can expand their families.

Most research on parenting has also focused on mothers. This is not surprising considering the cultural and normative expectations which frame cisgender women as inherently nurturing and caregiving because of their assumed capacity to become pregnant and bear children. Also, cisgender women, especially heterosexual cisgender women, are the majority group who become parents *because* of their capacity to become pregnant and bear children, and because of historical laws and policies which have controlled the rights to abortion and reproductive technologies that prevented marginalized groups, such as queer people, from becoming parents. With this in mind, I make sure to be clear when I am speaking about mothers or fathers in particular or parents in general rather than using "mother" as a catch all for "parent." Mothers and fathers will have different experiences, especially in relation to parenting, but I opt for gender inclusive language where appropriate to highlight parenting outside of "normal gendered" parenting. I am still careful to honor and acknowledge the undue pressures women in particular face in relation to mothering.

Chapter Outline

This project examines parents' perceptions of their bodies and embodiment throughout the course of becoming parents to provide insights into the ways bodies are surveilled, controlled, and constantly in transition. I utilize a life course perspective, intersecting with body and embodiment, to inform my conceptualization of *liminal embodiment*, the idea that our embodiment shifts through various social locations and identity formations throughout our lives.

Chapter Two outlines the relevant literature around body and embodiment, life course theory, and parenthood. I overview the existing understanding of these three areas of study to identify relevant gaps. I lay out the general arguments in the importance of an inclusion of life course theory within body and embodiment research to sociologists, particularly as it relates to fat stigma and parenthood.

Chapter Three explains my methodological approach and data analysis of my interviews as well as a discussion about my sample. I also discuss the ethical considerations and the strengths and weaknesses of virtual interviews. From May 2021 to June 2022, I interviewed 40 parents about their experience with and perception of their bodies throughout the course of becoming parents. I developed my interview protocol in two waves. My first 15 interviews occurred between May 2021 and October 2021 (Appendix B) and followed this initial interview protocol. I developed my second interview protocol in October 2021 (Appendix C) and the other 25 interviews followed this protocol. Minor changes were made from the first and second interview protocol, where I added more explicit questions about participants' bodies. In both interview protocols, in the first section, I asked general questions about their children and how they became parents whether through adoption, reproductive technologies, or conception. In the second part of the interview, in the first protocol, I asked more specific questions about their

experience as a parent, such as navigating judgement after they became a parent. In the second protocol, I shifted the second part to ask more specific questions about parents' bodies, asking them to recall how they felt about their bodies before, during, and after becoming a parent. Interviews lasted between one to three hours with an average of one and a half hours. I also draw from my own reflections as a fat, white, cisgender woman attempting to receive reproductive care to discuss the implications of positionality for the study results.

Chapters Four through Six presents the results of the study. Chapter Four examines the transition to parenthood and reveals the complex interplay between parents' bodies, societal expectations, and interactions in healthcare and social services. My participants' body expectations are influenced by societal standards and institutional actors' treatment based on their initial weight before they became parents. Thin and average-sized parents often view parenthood as an opportunity to defy thinness norms, yet paradoxically employ healthist language, reinforcing weight gain negativity. In contrast, fat parents face medicalization, moralization, and stigma, lacking the reprieve thin parents experience during pregnancy. The transition to parenthood is both social and physical, where adopting a parenting identity involves adopting new roles and physical expectations associated with parenthood. Thin parents may briefly embrace relaxed beauty standards, but fat parents, already outside hegemonic norms of thinness, encounter additional barriers in expanding their family.

Chapter Five examines parents' constructions of natural bodily processes in relation to reproduction, creating a hierarchy of birth experiences through and analysis of perceptions of their bodies as they are becoming parents, through gestation and birth and/or adoption. Parents' constructions of "good" birthing experiences reinforce embodied neoliberal ideologies of independence, individuality, and self-reliance. Gestational parents often negotiate their status as

mothers through constructions of "natural" birthing processes, which are primarily characterized by successfully having a vaginal birth. Parents who are unable to have biological children, who receive reproductive treatment, or who have C-sections reflect on the ways their bodies "fail" to produce children. Parents who avidly support "natural" vaginal birth simultaneously challenge the medicalization of childbirth while also reaffirming embodied neoliberalism of independence and maintaining a hierarchy of "good" and virtuous mothers.

Chapter Six examines parents' perceptions of their bodies and embodiment now, reflecting on how they feel about their bodies as they have had children, raised children, and aged. Parents' reflection of their bodies highlights social norms of beauty and the differing expectations for mothers and fathers. In this chapter, I identify three main characteristics as parents explain how their bodies have changed: nostalgia, health/weight concerns, and generational harm to children. Parents often reflect on their bodies when they were younger through a nostalgic lens, recalling their small body and wishing to be back their size. They also maintain concern for their health and weight but simultaneously do not want to pass on anti-fat generational norms to their children. Parents simultaneously reflect on their past self, often longing for a thinner body, but recognize the harm they experienced from their own parents who expressed anti-fat views.

I conclude with a discussion in Chapter Seven of my theorization of *liminal embodiment*, reflecting on the ways parenthood and the identity of parent offers valuable insights into the ways embodiment shifts with social location and identity formation. First, I conclude that life course theory is an important component of embodiment as individuals move through various organization and institutions, from new jobs, marriage, and education and how parenting is an explicit avenue to highlighting changes in embodiment. Second, I argue that my research

provides evidence for how parents, through the process of becoming a parent, simultaneously challenge, recreate, and reinforce hegemonic health ideals and embody neoliberal ideologies. Finally, my research argues that more care should be taken to ensure parents do not feel disproportionately stigmatized for their weight, especially when no immediate health concerns are present.

CHAPTER 2

REVIEW OF LITERATURE

This chapter reviews the literature on the sociology of the body and the life course. I connect the study of the body and embodiment with life course theory to bridge a theoretical gap, arguing for a more robust consideration and utility of the life course perspective in body and embodiment research. Doing so will give further insight into the ways bodies change over time and how these changes impact our life trajectories and transitions through important life events. I argue that embodied experiences, or how we experience our physical bodies in different spaces, has an impact on our sense of agency and ability to control our social pathways.

I discuss the landscape of the sociology of body and embodiment and the connections to neoliberalism and healthism through *embodied neoliberalism*. Social norms and other structures shape embodied neoliberalism, and although prior research has not implicitly brought the life course to bear on this topic, key life course theory tenets can help us understand embodied neoliberalism, as I argue that life course stages and transitions are inflection points for these norms and structures to take root. I then overview life course theory in sociology and its connection to the body, using anti-fat stigma as a focus point. Next, I introduce the study of parenthood in sociology and how parenthood offers a unique viewpoint for developing a theoretical orientation of embodied life course. Finally, I bring these literature together to argue how a life course perspective can strengthen body and embodiment studies as a theoretical orientation. The role and identity transition into parenthood offers a distinct perspective into how neoliberal ideologies are embodied through concerns about health status and parental fitness, and the transition also offers insight into how parents will diverge in their social pathways based on previous embodied experiences.

Sociology of the Body and Neoliberalism

Our bodies are the means through which we interact with our environment and each other. Our bodies are the initial entry point for navigating social institutions and interactions. Despite the importance of the physical body, it is often understudied in sociology. Sociology of the body and embodiment is a growing sub-discipline. However, researchers and theorists in sociology and beyond have acknowledged the body, even if they were not explicitly studying the body. For example, Engels ([1845] 2009) famously examined the working and economic conditions of workers in factories during the industrial revolution, and he also found that factory work permanently changed workers' bodies, who had hunched backs and "K" shaped legs.

Bodies, then, are impacted through social structures, institutions, interactions, and individual attempts to change the body. Additionally, our bodies can also physically show ideological leanings, such as changing and manipulating our bodies to adhere to our values of health and productivity, among others, which can impact how we perceive our embodiment through changing and often contradictory messages. I outline how neoliberal ideologies become "mapped" onto the body through healthism, leading to an embodied neoliberalism.

Sociology of the Body and Embodiment

Sociology of the body critically examines the relationship between the human body and society and how the body is influenced via societal norms, cultural values, and power dynamics which create and reaffirm inequality (ex. Roberts 2017; Elias, Gill, and Scharff 2017; Dame-Griff 2019; Boero and Mason 2020). Our perceptions, constructions, and experiences of the body influence how we engage with our environment and others. In other words, the body is a complex site for negotiations of social meaning, values, and inequalities.

Early scholarship in sociology of the body did not always come from sociologists or from sociologists who explicitly studied the body. However, many contemporary sociologists find useful analyses of the body from Friedrich Engels ([1845] 1845), Michele Foucault (1994; 1995), Erving Goffman (1986; 1990), and Peter L. Berger and Thomas Luckmann (1966).

On a structural and social level, Engels (1845) and Foucault (1994; 1995) marked the how institutions surveil and change the body. Working-class men in factories experienced deformations of their spines and legs (Engels 1845). Foucault (1994; 1995), through his analysis of medical institutions and prisons, shows how medicalization and criminalization lead to hyper regulation and categorization of bodies.

Alternatively, using a more interactionist approach, Goffman (1986, 1990) and Peter Berger and Thomas Luckmann (1966) show how the body is a vessel for interpreting the world. While none of these sociologists were explicitly analyzing the body, much of the body and embodiment literature point to them as instrumental in the development of an analysis of the physical body in interaction. Goffman (1990) emphasizes how individuals actively present themselves through different impression managements. His analysis of the presentation of self is not only important in how individuals manage their identities, but also their bodies. For example, Goffman (1986), through his analysis of visible and invisible stigmas, recognizes how body imperfections, in association with body norms, impact individuals' success in institutional and social interactions.

Berger and Luckmann (1966) are two more sociologists who did not exclusively analyze the body but have provided valuable insight into how societal institutions and interactions shape our perceptions, including those related to the body. They examine how we “play off” each other in interactions and how our understanding of “reality” in these interactions shifts as we become

closer to others. They use the metaphor of a continuum, where there are those we frequently interact with on one end, and on the other are "anonymous abstractions," those which are not available for face-to-face interaction. It is social structures that are the "sum" of close, face-to-face interactions and anonymous abstractions, in other words, it is interaction that creates social structures, i.e., society. Using an analysis of the social construction of reality through interactions gives insights into the body and embodiment. Our understanding of bodies is not simply biological, as the body is often relegated to the realm of physical sciences but is socially constructed through cultural and social contexts. Societal institutions, cultural norms, and interactions contribute to meanings of the body. For example, processes of socialization are central in Berger and Luckmann's (1966) work and body and embodiment scholars have analyzed the ways socialization from parents, peers, medical professionals, and media consumption can lead to poor body image and weight stigma (Bordo 1995; Saguy 2013; Tomiyama et al. 2018; Sabharwal et al. 2020) As the body has been tangentially explored through classical theorists, there is now a more focused effort by sociologists to recognize how the body is useful in understanding multi-faceted aspects of social life.

Scholars of the body research a range of topics, including identity, health, sports, disability, labor, and beauty, among others. Sociology of the body encompasses various levels of analysis, from interactional to structural. Brian Turner's (2008) seminal work locates the body within sociology, from health and illness to the relationship between sociology and theory. Turner (2008) was one of the first to critique the seemingly solid rejection of nature in the "nature versus nurture" debate of sociologists, citing the body as both a living organism and a cultural product. As a cultural product, the body and our embodiment is influenced by cultural values and ideologies. One ideology that has garnered attention in sociology of the body is that

of neoliberalism. While neoliberalism is often analyzed through frameworks of politics and economy, these ideologies are important for recognizing how individuals, constructed as neoliberal citizens, are meant to maintain normalized expectations of health to continue producing for the economy and their families.

Neoliberalism

Neoliberalism is a political framework usually associated with policies and laws. It is an ideology that emphasizes free market capitalism, rejects or minimizes government intervention, and views the market as the best way to allocate resources. As I describe below, this ideology also operates on a micro level through application of the general principles to individuals.

Minimal public and government intervention with an emphasis on individual responsibility is central to neoliberalism (Harvey 2011; Harjunen 2017). Through deregulation and privatization, federal, state, and local governments reduced spending to welfare programs and other state interventions for its citizens (Harvey 2011). Neoliberal policies deregulate businesses and remove government restrictions incentivize efficiency in the market, and privatize public welfare services into these deregulated companies. Services once considered a public good are turned into marketable economies, such as health care.

As the U.S. has adopted more neoliberal policies since the 1970s, the market has become a guide for human action, rendering us additionally responsible for our own health and wellbeing to ensure that we continue to be productive citizens (Harjunen 2017; Dame-Griff 2020). Under the scope of neoliberalism, individuals are now expected to practice self-surveillance and self-control to ensure they maintain their good health, absolving the state of responsibility of caring for its citizens. Healthism is the ideology which is enforced through neoliberal ideologies and

policies, where health is individualized, commodified, and viewed as a moral responsibility (Crawford 1980, 2006; Cairns and Johnson 2015; Harjunen 2017).

Healthism

Neoliberal ideologies have supported the institutionalization of healthism, a phenomenon which characterizes good health as more than a personal goal. Good health becomes a moral obligation that individuals are responsible for (Crawford 1980). In linking healthism to neoliberal ideology, neoliberal policies have rendered citizens responsible for their own health status as health care becomes increasingly privatized.

Healthism is characterized by individualism, moralization of health, a focus on prevention, medicalization of everyday life, and viewing health as a commodity. Healthism was first used in 1980 by Robert Crawford who examined how everyday life has become medicalized and has a profound impact on our beliefs, values, and actions. For example, Crawford (1980) examined the growing trend of "health consciousness" that arose in the 1970s. He argued that health consciousness had a distinctly middle-class edge, a focus on health different than working-class issues of the five-day work week and ending child labor. The participation in health is individualized through the conceptualization of self-care and lifestyle choice. In other words, the "solution rests within the individual's determination to resist culture, advertising, institutional or environmental constraints… or, simply, lazy or poor eating habits" (Crawford 1980: 368). Healthism also focuses on prevention, where there is worry about disease, illness, and impairment even when these are not present, and constant achievement of "better" health outcomes (Harjunen 2017; LeBesco 2011; Broom et al. 2014). The embodiment of healthism has increased with technological advancement, such as self-tracking applications and devices, associated with more diverse physical and mental characteristics (Sanders 2017).

Medicalization is defined as issues which become framed as medical problems and can be fixed via medical intervention (Broom et al. 2014). Health status is both medicalized, something to be fixed by medical intervention, but also an individual problem. For example, various ailments, such as high blood pressure and "obesity" are often treated via medications and surgical procedures. However, this creates a fear of developing various ailments and assigns responsibility to individuals to reduce their risk of developing different diseases through technologies of self-surveillance. Self-surveillance technologies have enabled individuals to monitor various outputs supposedly related to health status, such as step and pulse counters, weight monitoring, and various apps to track calories (Lupton and Jutel 2015; Lupton 2017; Sanders 2017). Under healthism with neoliberal ideologies, appropriate neoliberal citizens must always surveil their health, through privatization of health care technologies, to prevent themselves from becoming reliant on the state.

It is through the medicalization of health, where various characteristics of the body are seen as "fixable" only through medical intervention, that we have also seen an increase in the way individuals are expected to care for themselves and actively prevent disease and illness on an individual basis. Certain health behaviors, those which are seen to focus on prevention, are also moralized, framing certain lifestyles and health behaviors as more virtuous than others (Abel 2007, 2008; Korp 2008). However, these actions are contextual and dependent on other factors. For example, fat individuals, when going to the doctor, are more likely to feel as if their ailments are ignored in favor of focusing on their weight compared to thinner individuals. Fat patients are expected to cure their ailments more often through weight loss rather than other treatments (Tylka et al. 2014)

Medicalization lengthens the list of problems that can be defined as diseases and heightens medical authority in "fixing" the now labeled diseases (Broom et al. 2014). Neoliberalism and medicalization of our health puts individuals in a position to be constantly monitoring everything about their bodies, such as food intake, calories burned, blood pressure, blood sugar levels, number of steps walked, among others (Lupton and Jutel 2015; Lupton 2017; Sanders 2017). Over the last few decades, there has been an increase in home monitoring tools, where individuals can now monitor their bodies without going to a doctor (Harjunen 2017; Sanders 2017; Kirkland 2014; Broom et al. 2014). Expectations of wellness surveillance becomes a moral, social, and individual responsibility to a neoliberal state to ensure one remains a productive and reproductive citizen.

Embodied Neoliberalism

Neoliberalism and healthism work together by placing a strong emphasis and moralization on individual responsibility and self-reliance, market-based solutions, and the deregulation and privatization of health care. It is through the institutionalization of healthism that neoliberal ideologies become "mapped" onto the body and lived out through day to day interactions. The values of a neoliberal political economy, which include individuality, free-market choice, and little to no government intervention, influence the way individual bodies are valued and experienced. In other words, individual embodiment, or how we experience our bodies as we move through the world, is influenced through notions of individual responsibility and free choice, which transitions the responsibility of "good" health and citizen onto the individual rather than the state (Harjunen 2017). Healthism, then, is a byproduct of neoliberal ideology which normalizes and moralizes bodies through perceived "health" which becomes a proxy for "goodness". Neoliberal ideologies of individual responsibility, however, means that

health is no longer a public issue but a private one. I use these core concepts to analyze my data to better understand the experience parents have with their bodies as they move through the world, and how their embodiment is directly impacted by structural norms of personal responsibility, surveillance, production, and reproduction.

Life Course Theory

Life course scholars examine the ways individuals come to similar and different social pathways. In this section, I give an overview of life course theory and how life course scholars have contributed to an analysis of the body and embodiment, primarily focusing on aging. Life course perspectives are useful for understanding how physical changes impact perceptions of agency, life transitions, trajectories, and social pathways. I conclude this section examining anti-fat stigma over the life course. I review literature that demonstrates how body size and shape, specifically fatness, can alter access to various resources over the life course which can have negative outcomes for employment, health status, and educational outcomes. This review of life course literature will act as the theoretical framing for contextualizing parenthood as a specific embodied social pathway.

Life Course Overview

Life course theory examines the way individuals move throughout their lives across diverse pathways and trajectories influenced via social structures and agency (Elder Jr., Johnson, Crosnoe 2004). Life course theory examines the duality of agency and structure and nature versus nurture, often highly debated concepts within sociology. Life course theory offers ways to conceptualize different life outcomes even when individuals share similar trajectories and transitions.

Elder et al. (2004) identifies five primary components of life course theory: Life span development, agency, time and place, timing, and linked lives. First, development and aging are lifelong processes; there is no time when we simply stop developing and transitioning into different life stages. Second, life course theory emphasizes the intersection of agency and structure, that we are able to construct our own lives through choices and actions within opportunities and constraints of social circumstances. Additionally, agency and structure is also about how much choice individuals perceive themselves to have, particularly their perceptions of internal and external control over their lives. Third, life course is embedded and shaped through time, place, and history of one's experience. Fourth, consequences of life transitions vary according to timing. Five, lives are interdependent and will be shaped through shared networks.

Life course frameworks have traditionally been used in longitudinal studies of large age cohorts to examine diverse pathways through various trajectories and transitions. Trajectories are associated with the long-term involvement and connection to social institutions and the corresponding roles associated with these, such as family and parenting. Transitions are the specific events that move and individual into or out of various institutional contexts, like becoming a parent and transitioning in the institution of family, and the corresponding role configuration of parent (Elder Jr. et al. 2004; Macmillan and Eliason 2004). In other words, trajectories are associated with moving within an institution whereas transitions are moving between. Transitions, in relation to my work, are particularly important for considering how individuals make sense of and respond to normative transitions related to parenting.

Life Course and Transitions

Transitions can occur within and outside of our control. Generally, experiences such as marriage and career changes are associated with personal choice whereas illness and deaths are

not (Chick and Meleis 1986). Transitions are defined as “passage from one life phase, condition, or status to another” and includes “elements of process, timespan, and perception" (Chick and Meleis 1986: 239). Transitions can also straddle the line of perceived control. For example, life course scholars writing about transitions into parenthood tend to define pregnancy as an expected and wanted transition for which individuals prepare *prior* to becoming pregnant, saying the choice to become a parent is “generally” a conscious one (Chick and Meleis 1986; Levin-Keini and Shlomo 2019). However, pregnancy can occur for various reasons outside of our control, such as fault contraception, using contraception incorrectly, or the lack of abortion access, making it not always an agentic “choice” (Kimport 2022). Regardless if parenting is a conscious choice or not, parenthood is socially constructed as a “normative” transition and is highly valued in most cultures (Walker 2014).

Life course scholars have defined transitions in two ways, normative and non-normative transitions (Chick and Meleis 1986; Furstenberg 2005; Peterson and Place 2019). Normative transitions are meant to follow general patterns though the responses to transitions are not universal. Parenthood, for example, is experienced through a complex series of emotions defined through joy and loss, particularly the “loss of one’s former shape, loss of previous relationships, [and] loss of free time” (Levin-Keini and Shlomo 2019: 240). The general structure of a transition includes entry into the new phase, passage through, and then exiting on the other side of the event, adopting a new role or status (Chick and Meleis 1986; Peterson and Place 2019). If specific patterns are not followed, where non-normative transitions occur, individuals may experience disruption in their identity formation, destabilization of relationships, and question their self-worth (Peterson and Place 2019). Peterson and Place (2019) examine how infertility for men and women disrupts their gender identity and disconnection from others who are perceived

to “continue onward”. To become a parent, barriers of infertility can cause distress and interpersonal challenges when biological parenthood is considered a normative expectation and life goals.

Not all responses to non-normative transitions are negative, or perceived as such, especially given enough time to respond to various transitions. For example, women who have unexpected C-sections may recall feelings of disappointment regarding the need for a C-section, leading their transition into parenthood being labeled as non-normative compared to vaginal births. Over time, this non-normative transition may be more accepted once mothers can reflect on why they needed the C-section in the first place (such as an emergency) and seeing the health of their baby (Sahlin et al. 2021). Furstenberg (2005) finds that institutional gatekeepers, such as family, education, and legal authorities, help set and reinforce social timetables and expected outcomes for normative transitions. Institutions and institutional gatekeepers allocate resources or penalties for those who maintain or violate age norms (Furstenberg 2005). For example, normative transitions are constructed through the framework of time, both regarding age at a particular event and the order in which events occur. Teenage pregnancy is considered non-normative precisely because of the age of the, usually, girls, and because they are viewed as breaking the established pattern (becoming pregnant before marriage or finishing their education). Furstenberg (2005) finds the negative connotations associated with teenage pregnancy is most often due to popular values and ideologies which frame teenage girls’ lives as being “over” due to their pregnancy. However, most young girls respond to their non-normative transition into young parenthood positively, as they “construct, interpret, and make meaning of their actions in ways that have powerful consequences for themselves” (Furstenberg 2005) and do not experience the negative outcomes usually associated with teenage motherhood.

Previous literature on transitions has focused on how individuals internally and externally experience their transition through emotional responses and messaging. However, life course transitions are also experienced through the body, as bodies change over time and influence the ways in which we experience the world. Through a life course perspective, the world is "experienced through a series of developmental transitions across the lifespan that are embedded within… social, cultural, historical, and **physical** influences" (Peterson and Place 2019, emphasis mine).

Life Course and the Body

Sociology of the life course has a history of including the body in various analyses. As life course theorists can attest, the ways the body changes over time are influential including the importance of puberty in development, health behaviors over time, and the act of aging. For example, aging is a distinct and universal process which impacts social location and identity. Aging as a prominent transition period of the life course, particularly when individuals shift from employee to retiree, is helpful in understanding the importance of the body through a life course perspective. Life course sociologists Chris Phillipson and Jaber Gubrium have examined how aging impacts identity and embodiment, particularly for older adults. In an aging society, it is imperative to consider the structural, social, and individual components of aging. Phillipson (1982; 1998) uses a Marxist perspective to analyze how aging is constructed against the backdrop of capitalism. Aging, under a capitalist system, moves individuals from the status of "worker" to being redefined as "old age pensioner" when they leave the work force and begin collecting social security. Phillipson (1982; 1998), while identifying aging as social construct via capitalism and labor, where "aging" is most prominent when one leaves the workforce, he also identifies and importance of aging in relation to identity and role status.

Older adult experiences are often alienating not only because of their changing roles in society, but also their changing bodies. Older adults are often constructed as a "burden" because of their newfound physical and mental needs (Phillipson 1998; Gubrium 2001). In the context of life changes, older adults are often discounted, especially when they move into nursing homes (Gubrium 2001). Because of this, Gubrium (2001) argues for a narrative articulation of older adults, saying "[older adults] don't leave their lives behind when they check in [to nursing homes]" (27). Aging and the life course are intrinsically intertwined because of the explicit ways in which aging is defined in our society, as something to often be avoided and ignored. Life course theorists have made significant contributions to linking the body and the life course through an analysis of aging.

Through the example of aging, life course theorists have provided a clear framework for how the body is linked with social and physical change. While aging a clear example of changes over the life course, such as the perceived loss of independence and bodily control, there are other ways the body changes over time which can impact social pathways and life trajectories but are often less clear than the process of aging, such as weight gain. Body shape and size are also influential in social pathways, including education, employment, and marriage.

Anti-Fatness over the Life Course

Life course theory focuses on the ways individuals move throughout their lives, examining diverse social pathways even for those in similar social locations. These variations are associated with differences in perceptions of agency and social constraint, where our abilities to make choices are constrained by social structures and how much we feel we have control over our lives. Aging is a common and well-established focus of the life course, as are other transitions like completing education, entering the labor force, and marriage. However, how

physical bodies change over time will impact the access one has to the above expected life trajectories, such as body shape and size due to anti-fat stigma and disability due to ableism.

Researchers have found that weight gain can impact access to employment, health care, and education which can have dire consequences for those living in larger bodies (Puhl and Brownell 2001; Crosnoe 2007; Reece 2019). Fat individuals are often characterized as inherently lazy, unhealthy, and unintelligent because of their supposed lifestyle choices (Crawford 1980; Rennels 2015; Gordon 2023). While these characteristics are often highlighted in media for comedic effect, these messages are structural, impacting various institutions which can prevent fat individuals from accessing necessary resources which could alter their social pathways. These messages also inform institutional actors, where discrimination is enacted and repeated by individuals, eventually becoming institutionalized where the cycle continues.

Lower socio-economic status correlates to higher weight, but the directional link is complicated, with weight sometimes an outcome and sometimes the determinant of an outcome (Ernsberger 2009; Benson, Von Hippel, Lynch 2018). Regardless of the direction of the relationship, research shows there is weight-based discrimination linked with socio-economic status. With consideration of a life course perspective, we can examine how body shape and size influences social pathways and life trajectories related to employment and the barriers to higher economic status.

Research linking socioeconomic status and "obesity" has often blamed the status of poverty for weight gain (Sobal and Stunkard 1989; Sobal 1991; Sørensen 1995). Sørensen (1995) recognizes that socio-economic status and obesity are not simply cause and effect and highlights the need to recognize the complexities of the ways class status and weight gain interact. The connection of poverty and weight gain is easy to make when poverty is associated with a lack of

safe places to exercise, access to fresh foods, and access to quality medical care. Additionally, those who live in poverty are also more likely to have fewer years of education which can correlate more unhealthy behaviors and negative health outcomes (Zajacova and Lawrence 2021). Fat people are often framed as lazy and unmotivated due to their perceived inability to lose weight, or at least a lack of trying. Additional research has found it is not so much poverty causing weight gain, but rather that weight gain can lead to lower economic status because of weight discrimination. Fat people face hiring prejudice and inequity in wages, promotions, and termination (Puhl and Brownell 2001; Ersenberger 2009; Reece 2016).

Life course studies show that health and health behaviors are influenced by educational attainment (Hayward and Sheehan 2016; Zajacova and Lawrence 2021), aging (Elder Jr. and George 2016), and family dynamics (Hofferth and Goldscheider 2016) as well as changes in body size and weight (Puhl and Brownell 2001; Balkhi, Parent, and Mayor 2013; Washington-Cole et al. 2017; Shaw and Fehoko 2022). Health care access is a necessary and important part of maintaining a healthy life, particularly through access to preventative care but there are multiple challenges and barriers to quality health care for fat people. Previous research has found that fat individuals often experience medical discrimination (Puhl and Brownell 2001; Balkhi et al. 2013; Washington-Cole et al. 2017; Shaw and Fehoko 2022), finding that doctors in one study rank "obesity" as the fourth common category which elicit feelings of discomfort or dislike, just after drug addiction, alcoholism, and mental illness (Klein et al. 1982) and that implicit anti-fat bias is prevalent even in health care professionals (Teachman and Brownell 2001).

Finally, anti-fat stigma has implications for fat people's educational success and is more explicit at higher levels of education (Puhl and Brownell 2001). Crosnoe (2007) finds a gendered outcome of weight-based stigma and education, finding that fat girls are less likely to attend

college directly after high school than their thinner peers. However, this difference does not hold true for boys, where boys of all sizes had similar rates of attending college directly after high school. Overall, fat men and women were underrepresented in college and fat women were additionally less likely to receive financial support from their parents (Crandall 1991).

Anti-fatness can have lasting consequences over the life course. Fat people are regularly denied employment opportunities, adequate health care services, and an accessible education. A unique aspect about body size in relation to the life course is that the body is not static. While much research has challenged individual frameworks of weight gain, arguing that weight loss is more complicated than it is often portrayed, the reality is that our bodies will fluctuate over our lifetimes, including weight gain and loss. With this consideration, weight fluctuations over the life course are important events worthy of further analysis. While weight gain and loss can happen at any point in time, one of the most noticeable, acceptable, and dreaded time for weight gain in during the transition to parenthood (Siega-Riz et al. 2004; Laroche et al. 2013; Vanstone et al. 2017).

Parenthod

So far, I have given an overview of my main theoretical perspectives, including embodied neoliberalism and life course theory. I now turn to parenthood to further contextualize how parenting is a unique and relevant life transition that is useful for understanding embodiment through the life course. First, I introduce the connection between neoliberalism and reproduction, showing how neoliberal ideologies have permeated reproduction through individualization and commodification.

Embodied Neoliberalism and Reproduction

As stated previously, embodied neoliberalism is the way in which neoliberal ideologies become "mapped" onto the body, where our everyday lived experiences are impacted, constrained, and influenced by neoliberal ideologies. Neoliberal ideologies individualize and commodify reproduction, and parenting in general, through the importance of personal responsibility, and capitalizing on procedure such as surrogacy and in vitro fertilization (IVF), which commodifies parenthood.

Bobel (2004) analyzed how motherhood is constructed within a paradox of individual choice and responsibility while also being heavily constrained by social messaging of "good" motherhood. Women in Bobel's (2004) study asserted that they were freely choosing to participate in intensive natural mothering, a kind of mothering characterized by high attachment and natural birth and food practices. Women felt they were making the best choice for their children, taking individual responsibility for the wellbeing of their children, while also supporting gendered roles in reproductive labor. Women who practice intensive natural mothering, while feeling agentic in their choice, also reaffirm gendered and sexed expectations of the body, that because their bodies are built to have and raise children, it is only natural that they remain home with them.

Neoliberalism also extends market principles into the realm of reproduction. The commodification of reproduction technologies, such as IVF and surrogacy, have become consumer goods which are accessible to only a small number of individuals at the expense of marginalized women, especially poor and disabled women. Additionally, surrogacy as a commodified reproduction product, constructs women of color's bodies as for sale to produce children for upper-class, mostly white, women.

Reproductive justice seeks to expand the framework of "choice" and "rights," with an emphasis on a right to have a child and parent is just as important as the right to not have children (Luna and Luker 2013). With more access to assisted reproductive technology, such as IVF and surrogacy, an assertion can be made that there are now more options for women to become pregnant. However, these technologies that are meant to assist births, similar to those that prevent births, reproduce racial hierarchy, where mostly white, heterosexual, middle class families have access to and use these technologies (Roberts 2017).

When looking at popular images of successful IVF and surrogacy, we are often met with images of middle-class, professional, white families and "perfect" white children with blonde hair and blue eyes (Roberts 2017). By acknowledging the whiteness of these technologies and the push to provide larger, genetically related white families, we can see the racialization of reproductive technology where choice is determined by one's ability to pay for it and those in power determining if one will make a "good" mother (Roberts 2017). For example, poor and single mothers are often demonized as potential mothers, where medical providers will not perform these procedures unless one can "prove" they are a good mother, where the proof is contingent on conforming to white, heterosexist ideals of family. Another example from Sole-Smith (2019) chronicles the stories of fat women who were denied fertility treatments because of their weight. Technologies, such as IVF do not actually create more freedom or liberation from traditional family structures but reinforce them (Roberts 2017; Weinbaum 2019). On one hand, IVF has allowed cisgender lesbian couples to have biological children, but the vast majority of those using this technology are white, heterosexual, married, middle-class couples who can afford upwards of $20,000 for IVF treatment, which is often not covered by insurance providers (Roberts 2017; Weinbaum 2019). Fertility treatments are also not fully reimbursed through

Medicaid, meaning that medical providers are more likely to deny these procedures due to losing money (Roberts 2017).

Instead of advocating for more access to fertility treatments, laws and policies have been passed to further deny poor women, particularly poor women of color, from accessing ways to grow their family (Smith 2005; Roberts 2017). In 1960, Planned Parenthood commissioned a study asserting that poor and working-class families "lacked the rationality to do family planning" unlike middle-class couples (Smith 2005: 128). In the 1990s, states passed laws preventing Medicaid from covering fertility drugs, citing the goal to "reduce welfare dependency, not create more of it" (Roberts 2017: 254). However, even without laws in place, doctors are also able to deny service to potential parents on the basis that they may be "high-risk" (Sole-Smith 2019). Fat women are often denied fertility treatments because their bodies are seen as inherently "risky" bodies for potential children (Sole-Smith 2019; McPhail et al. 2016). Bodies continue to be judged for their potential danger to unborn children. Rather than providing additional avenues for individuals to become parents, those in the role of "expert" are able to exert power over others and deny certain people the right to have children by encoding the notion of "risk" with racist, classist, ableist, and fatphobic ideologies.

Surrogacy is a reproductive technology that can be done on a more informal basis than IVF. However, many Black women scholars have critiqued the practice of surrogacy, primarily in the Global North, linking it to chattel slavery and the control of Black women's reproductive capabilities and the assumed inherent possession of their bodies (Roberts 2017; Weinbaum 2019). Weinbaum (2019) locates surrogacy in what she calls the "surrogacy/slavery nexus," where surrogate mothers are only considered for their bodily labor and responsibility to contractual and often coercive agreements, ideologies that were formed during chattel slavery

(Roberts 2017; Weinbaum 2019). Surrogate mothers are often viewed as "unnatural" mothers whose reproductive labor is alienable and the product of their labor belongs to someone else, where the surrogate mothers are "entitled to payment for their labor but not to the product of that labor" (Weinbaum 2019: 44).

The surrogacy/slavery nexus becomes even more complex when considering the technological advancement of IVF. Traditional surrogacy usually used the surrogate mother's egg and the consumer father's sperm. However, with IVF, the surrogate mother can carry a child that is not genetically related to her but carries the genetics of the couple who have paid her (Roberts 2017; Weinbaum 2019). Now, surrogate mothers are cast as incapable of "possessing a meaningful biological, psychological, or legal relationship to the child she gestated and delivered" (Weinbaum 2019: 50). Roberts (1997) and Weinbaum (2019) consider the contemporary coercive nature of surrogacy now that white couples can ensure that their children will be white even if gestated by a woman of color. Gestational surrogacy, surrogacy where the gestating mother has no genetic ties to the fetus, renders the possible racial identity of the child irrelevant (Weinbaum 2019). Considering, for example, that those who are most likely to utilize surrogacy are those in the global north, there has been a rise in the utilization of surrogates who come from the global south, creating a biocapitalist, globalized, low-cost surrogacy network that fosters exploitation of poor women of color (Weinbaum 2019).

Access to reproductive technology is constructed within racist, classist, ableist, and fatphobic frameworks, where experts are able to deny certain individuals from becoming parents on the basis that their bodies are "unruly" or "unfit" for parenting. Parenting is already a deeply embodied experience, with some parents feeling like they and their bodies are failures for not being able to conceive "naturally," having C-sections during delivery, or miscarrying (Villarosa

2018; Sole-Smith 2019). With more technological advancement, there are certainly more avenues for child-rearing, though these options are often not afforded to groups that have already been framed as unfit parents.

Healthism, Medicalization, and Parenthood

As stated previously, healthism and medicalization are two cultural and social phenomena that have been linked to neoliberalism, particularly how neoliberalism is embodied. Healthism refers to the individualization of health responsibility, where health is simultaneously commodified and seen as a moral duty (Crawford 1980). Under the umbrella of neoliberalism, health norms and the attempt to achieve a healthy lifestyle also frame one as a productive and responsible neoliberal citizen (Harjunen 2017).

Medicalization, then, is the process by which non-medical problems and/or characteristics become defined and treated as medical issues (Crawford 1980; Broom et al. 2014). These medical issues, or the risk of medical issues, can only be solved through medical intervention. Medicalization has swiftly expanded the definition of conditions that are perceived to need medical intervention. In the case of parenthood, there has been an increase in the medicalization of pregnancy, childbirth, in response to historical rates of infant and maternal mortality, and child-rearing, which parents must navigate to challenge and acquiesce to these expectations (Turner 2002; Bobel 2004; Parry 2008; Cripe 2018; Morris 2020; Effland et al. 2021). However, framing parenting bodies as inherently at risk, through what Lane (1995) calls the Medical Model, reaffirms messaging that the body is always ready to fail and risk narratives become a form of social control.

Researchers have argued that reproduction has become increasingly medicalized, especially with the increased rates of cesarean sections in the U.S., more births happening in

hospitals, and increased monitoring of pregnancy (Parry 2008; Morris 2020; Effland et al. 2021). While some researchers have critiqued the medicalization of childbirth, others have critiqued the so-called "natural birth" movement. Natural birth is defined through little to no medical intervention during childbirth, including pain medications, such as epidurals, and/or inducing labor. The main concern for having a "natural" birth, is the resistance to C-sections (Cripe 2018). Mothers who opt for giving birth at home or in midwifery centers are often exalted as being more concerned with their and their baby's wellbeing and health (Hird 2007; Malacrida and Boulton 2012). However, even births within midwifery centers have been questioned about the potential for being "natural" birthing places (Turner 2002). While there is critique of the natural birth movement, many women attempt to resist what they perceive to be more medicalized births because of they feel medicalized births may say about them as mothers (Parry 2008). When mothers are unable to participate in what they perceive to be a natural birth, they must contend with neoliberal ideologies which frames mothers as failures for "needing" medical intervention. To need medical interventions is to not adhere to values of individual responsibility of our own health. Healthism is a cornerstone of reproduction as parents are expected to maintain "good" health and health behaviors for the sake of their children, especially when their children are born. Women who become pregnant are particularly impacted by this because the health of their bodies are also linked to their children, and when they are perceived to need assistance through medical intervention, they risk being perceived as inadequate mothers.

Parenthood is a unique social status in conjunction with embodied neoliberalism and healthism. Under neoliberal ideology, the citizenry is meant to take care of themselves individually, including their health by making supposedly "good" lifestyle choices. In other words, it is our responsibility to make morally right decisions about our health to remain

productive neoliberal citizens and not put a strain on the state. However, shifting into the role and status of parent jeopardizes neoliberal ideology of individuality as parents undergo increased health and body surveillance because of the link to their children, the future neoliberal citizens (Boero 2009; Dame-Griff 2016, 2019, 2020; Lee 2020). Individual health choices are generally predicated on neoliberal ideology, but parents are no longer trusted to make the "right" decisions about their health and bodies at the risk of harming their children. However, this risk is still defined as individual, such as not trusting mothers to make adequate decisions about their health, than as structural or social conditions which may lead to pregnancy complications (Lane 1995).

Parenthood: An Embodied Life Course Theory Approach

Family and gender scholars have examined how reproduction and parenting is a specific rite of passage into adulthood, especially when considering moving from the social role of child to adult. Rites of passage consist of three phases: a movement out of one's previous social role, a liminal period between old and new role, and the attainment of a new role (Davis-Floyd 1992; van Gennep [1909] 2019). Van Gennep ([1909] 2019) focused primarily on pregnancy and birth as prominent moments in social transition and how various societies incorporate different rites of passage to mark the transition into parenthood, especially motherhood. Motherhood can be categorized through these three distinct phases of rites of passage: prenatal, natal, and postnatal (Molina 2019).

Becoming a parent, for women, is a specific and valued social location which marks the transition from child to adult. Feminist scholars have theorized upon the rites of passage for motherhood, arguing that becoming a mother is not merely a transition into parenthood but distinctly into adulthood for women which is both social and physical (Layne 1990; MacCormack 1994; Malacrida and Boulton 2012). Motherhood, therefore, is constructed as one

of the most important and valuable positions women can attain, leading to altered conceptions of self and identity formation through these socially constructed rites of passage.

It is not enough to simply consider the social expectations of a rite of passage in relation to motherhood. Life course theory contributes to a growing understanding of the overlap between structure and agency, how we take in cultural messages about given role expectations to develop our own identities. In other words, one becomes a parent through identity salience and role congruence within the role of parenthood (Stryker 1968; Cast 2004; Ladge, Claire, and Greenburg 2012; Ladge and Greenburg 2015).

Adopting the identity of "parent" brings together the social roles and statuses of being a parent and becomes internalized, where, for example, a mother will then reflect social expectations of motherhood back on herself, thus forming her own relationship to this new identity (Cast 2004; Ladge, et al. 2012; Ladge and Greenburg 2015). For example, Malacrida and Boulton (2012) find that societal messaging of "good" motherhood are also linked to expectations of "good" birth. "Good" births are framed through natural birthing process, vaginal births with little to no medical intervention such as epidurals for pain relief. Women in this study offer competing narratives regarding birth choice depending on their parental status, or achieved parental identity, either as a parent or non-parent. Women without children were more likely to say they wanted cesarean sections because of the negative associations with vaginal births and assumed deterioration of the vagina for penetrative intercourse. Mothers, on the other hand, view vaginal births specifically as a transition to *selfless* motherhood precisely because of the sacrifice of their body to birth their children. The process of becoming and being a mother shifts the way women perceive themselves and their bodies through the act of being pregnant and giving birth.

Due to gendered expectations, research on parenting tends to focus primarily on cisgender women. Cisgender women often identify more strongly with parenting expectations because of the physical toll of pregnancy and the socialization toward an expectant future of motherhood from a young age and through adulthood. Women who become mothers experience not only the transition into adulthood but also a distinct relationship to womanhood compared to women who not have children (Malacrida and Boulton 2012). Women's perceptions of childbirth highlight tensions found in normative femininity, such as contradictions of women as simultaneously sexual objects and desexualized caregivers. Women must contend with heightened role expectations as mothers face immense pressure to, traditionally, take on most childcaring duties, and their identities can be challenged if, for example, husbands take on more of the child caring responsibilities, challenging parents' role verification and their identity as parents (Stryker 1968).

An embodied life course theory in relation to family studies and parenthood is useful in examining the ways individuals understand themselves as parents through internal and social processes. However, these analyses primarily focus on shifts in social location, interpersonal relationships, gender roles, and birthing processes (Stryker 1968; Davis-Floyd 2022; Cast 2004; Choi, Baker, and Tree 2005; Malacrida and Boulton 2012). From a body and embodiment standpoint, little research has examined social pathways and the influence from previous embodied experiences, and that the physical body and embodiment is an important component of the transition into parenthood. While birth and pregnancy are physical attributes of transition and the changing body, analysis is limited in how parents perceive their changing bodies in conjunction with social messaging about appropriate parenting bodies and size.

Conclusion

In this review of literature, I have outlined my core theoretical frameworks to conceptualize my research, First, I outlined how the theorization of sociology of the body is linked closely to neoliberal ideology, particularly through the connection of neoliberalism and healthism which in turn informs an embodied neoliberalism. Embodied neoliberalism suggests that our embodiment is informed by individual responsibility and general functionality to remain a good, neoliberal citizen. Second, I connected the importance of introducing a life course perspective to the analysis of sociology of the body and embodiment. Life course is defined through transitional phases and is a useful lens for analyzing how the body shifts and changes, impacting our social pathways. For example, I give show past research which explores the ways fat individuals experience barriers to employment, education, and marriage because of anti-fat bias. Finally, I introduce the social transition into parenthood as the lens through which I examine my theoretical intersections of life course and sociology of the body.

By linking life course and sociology of the body, using the lens of parenthood, to my data and results, I aim to develop what I am calling *liminal embodiment.* Liminal embodiment is the conceptualization that bodies are always in transition, and that our embodied experiences and ideologies are important moments which influence our perceptions of agency and our various transitions and life trajectories. Through neoliberal values, individual health status and healthy lifestyles have become commodities and moral obligations. These changes impact social pathways when individuals are unable, or are perceived as unable, to adhere to embodied neoliberal tenets of health and productivity, such as by being fat.

I argue that embodiment is also how we experience various ideological values. Further, these values can change over time and therefore change our embodiment. For example,

neoliberal ideology, that highlights deregulation and individualism, has paved the way for healthist ideologies and values which moralize health and medicalize our everyday lives. Individuals are now seen as morally superior through the lifestyles and bodies that represent good health. What is important, also, is how these socio-historical contexts impact our social pathways and life trajectories. Life course theory covers transitions through different phases in life, moving within and between institutions, roles, and statuses. While we have agency, this is not merely an internal process. Our life course trajectories are also embodied. For example, in employment, Engels (2009) famously examined factory jobs and how this work permanently changed the bodies of working men, such as hunched backs and "K" shaped legs. The body is also seen as a sort of "record" of life transitions, from puberty, to pregnancy, and aging. Through a life course perspective on parenting, I argue that the socio-historical context of neoliberal healthist ideology manifests and we literally embody values of individualism, moralization and commodification of health, and constant productivity. I use parenting as the lens through which I examine my theorization of liminal embodiment, where social pathways are linked with bodily transitions in various socio-historical contexts.

Bodies are also not static, and consideration must be made for previous embodied experiences and how bodies change over time. Life course theory offers a strong theoretical foundation for examining how individuals may follow similar or diverge in their transitions and trajectories based on previous embodied experiences. Through *liminal embodiment*, I argue for a life course perspective in body and embodiment to strengthen the analysis of how bodies change over time and how these changes impact our life trajectories and transitions through important life events, including employment, access to health care, and education.

I use the distinct experiences of the transition to parenthood to examine liminal embodiment, particularly because of the ways in which parents' bodies obviously change over a short period of time and become increasingly surveilled by themselves and others to maintain their health for the sake of their children. Parenthood is a clear example of the way bodies become a focal point of transitional life phases.

CHAPTER 3

METHODS AND ANALYSIS

Methodology: Interviews

To examine how parents perceive their bodies, I conducted phone and video-conferencing interviews. I used interview methods because I wanted to understand the "specific situations, individuals, [and] moments in time" that are important to my study population (Rubin and Rubin 2012: 2). My approach to gathering data is informed by social constructionism, focusing on how individuals "perceive their worlds and how they interpret those experiences" (Rubin and Rubin 2012: 3). My call for participants included parents of all genders and relations to their children, including biological and adoptive parents. While the majority of my participants are cisgender women who have given birth to their children, I found it important to highlight family structures outside of the nuclear family and to also give fathers an opportunity to speak about their experience as parents. Having a more generalized call for "parents" rather than just mothers also disrupted the gendered assumption of mothers as primary caregivers and as the only ones who experience embodied changes through the course of parenthood.

I conducted 40 in-depth, semi-structured interviews with parents to gain insight into parental bodies and embodiment. Interviews lasted between one and three hours with an average of one and a half hours. Due to beginning data collection at the height of the COVID-19 pandemic, I conducted interviews over the phone and via video-conferencing using Google Meet. Google Meet was chosen because it could easily be used in an internet browser and did not require participants to download any additional software. I also offered participants the choice to participate in the interview over the phone. Most (29) participants opted for a phone

interview to allow for flexibility. I recorded all interviews and transcribed them soon after the interview concluded. I assigned pseudonyms to all participants. I conducted my study in two phases. The first phase was conducted between May 2021 and October 2021. I conducted the second phase of interviews between October 2021 and June 2022.

I used a retrospective interview method, asking participants to recall their perceptions of their body and embodiment before, during, and after they became a parent. Retrospective interviewing is often criticized for greater inaccuracy, especially the longer time between various life events (Parry, Thomson, and Fowkes 1999). However, longitudinal research has suggested that accuracy of recall, specifically regarding body weight and size, does not diminish as greatly as previously thought (Casey et al. 1991; Must et al. 1993). Additionally, using "key life transitions and turning points can provide a framework within which socio-biographical detail can be usefully explored" (Parry et al. 1999: 2). Therefore, while there can be critique of interview methods as providing partial or biased information, previous research has found that participants may actually be more consistent in their recall especially when prompted to remember specific events.

Retrospective interview methods are, overall, a strong way to collect the kind of data that best answers my research questions, particularly examining participants' specific and in-depth consideration for their life experiences.

The methods in which I conducted interviews have their strengths and weaknesses. There are advantages and disadvantages to phone and virtual interviews compared to in-person interview methods (Scott 2004; Holt 2010; Sturges and Hanrahan 2011; Trier-Bienick 2012; Heath et al. 2018). In-person interviews have the benefit of a more embodied interview methodology, where the interviewer can examine not only what is being said in an interview but

also the body language of the interviewee (Ellingson 2017). Interview notes not only encapsulate what is being said but can act as field notes, marking clothing and physical responses to questions. There is some research to suggest that telephone interviews are not as effective as in-person interviews (e.g. Shuy 2002). However, Trier-Bieniek (2012) argues that much of the reservation for doing qualitative research over the phone is due to the connection of telephone surveys and quantitative methods, arguing that telephone surveys are usually used more for efficiency of data collection rather than quality. Others have argued that there is no significant difference in the quality of data collected from a telephone interview compared to in-person (Sturges and Hanrahan 2011; Holt 2010) and that telephone interviews, when paired with previous communication such as E-mail or online message boards can also reduce feelings of shyness in participants (Scott 2004). Telephone interviews also allow for a wider range of participant options (Trier-Bieniek 2012), which has shown to be a positive in regard to scheduling times and being able to pick up the interviews at different times throughout the week with participants from across the U.S.

Telephone and virtual interviews lose important embodied markers. However, there are strengths to remote interview methods as well. Besides the need to socially distance during the COVID-19 pandemic, the primary strength is flexibility and many of my participants were able to participate in the interview while they were doing other activities, such as waiting for their children to finish with school or cooking. Additionally, if a participant had to end an interview early it was easier to schedule a follow up date and time to complete it. Telephone and virtual interviews also allowed for participants to describe their bodies on their terms, using words that resonate most with them. I was able to avoid making my own assumptions about their body size.

I had two phases of my interview to account for updating my interview guide using a grounded theory approach (Charmaz 2014). During Phase I of interviews, I used an interview schedule to guide the interview which included 15 participants (Appendix B). For the most part, all questions in the interview schedule were covered, however, questions and question order were often modified in accordance with participant's responses during the interview. I implemented these changes in response to coding initial interviews and seeing that participants would often avoid discussing their bodies unless explicitly asked. In Phase II, I made moderate adjustments to my interview schedule to ask more explicit questions about participants' perceptions of their bodies before, during, and after becoming a parent (Appendix C). While the questions acted as a guide, I followed the lead of my participants to follow-up or probe further into topics not explicitly covered in my interview guide, such as asking "can you tell me more about…?". Interviews lasted approximately one and a half hours, with a few as long as two and three hours. Interviews were scheduled at the participant's convenience. Due to the nature of interviewing parents, I made myself available to hold interviews throughout the day and into the evening, during weekdays and weekends.

Recruitment

Prior to data collection, my goal was to enroll 40 parents, which I accomplished and stopped collecting data once I hit saturation. Eligibility included being over 18 years old and being a parent, either through biological relation or adoption. I purposely used open language, such as recruiting "parents" versus "mothers" to try and recruit more fathers. In the end, the majority of my participants, 36, identify as cisgender women. My interpretation is that this is indicative of the ways that parenthood is often synonymous with motherhood.

I recruited participants through social media and personal networks. An invitation to participate (Appendix D) was posted to my personal Facebook account. I also asked friends and acquaintances who had children if they would be willing to participate. I utilized snowball sampling asking participants after interviews if they would be willing to share the invitation to participate (Appendix D) within their own social networks (Berg and Lune 2012). I also posted my recruitment flier to specific social media groups related to parenting. I used purposive sampling, sampling individuals who possess specific characteristics, where I purposely recruited parents who identify as fat, overweight, or plus size. I did this by initially contacting fat friends, acquaintances, and posting to fat centric Facebook groups. I wanted to be sure fat parents were included due to fat parents being understudied in family and reproductive literature. When posting to groups on social media, I was sure to contact the admin and moderators of the group before posting in order to get permission. I posted as well to my own social media pages where social media friends were able to also share my recruitment flier.

The invitation circulated provided details about the study, its purpose, and emphasized the research is voluntary and confidential. I also noted that participants were welcome to participate even if they wish to not be audio recorded, though all participants agreed to being recorded. I recognize that by not utilizing random sampling techniques means that I interviewed individuals who potentially had more awareness of body-related stigma and were also aware of my own opinions about anti-fat bias. Using a retrospective interview method, in this regard, can be helpful then to highlight how individual perceptions of their bodies change over time as they potentially adopt or reject more awareness about anti-fatness.

Sample

My sample includes 40 adult parents. Participants are between the ages of 26-63, predominately white, and have diverse sexualities, education status, and family make-up. Participants include 36 cisgender women, 3 cisgender men, and 1 non-binary person. I include parents who have biological, adopted, and/or foster children.

Table 1: Demographic Characteristics

Name	Age	Race/ Ethnicity	Gender	Sexuality	Relationship	Education [5]	Employed	Kids	Relation
Daniel	29	white	man	homosexual	married	HS	no	1	adopted
Taylor	27	white	woman	pansexual	separated	HS	yes	2	bio
Sam	37	white	man	homosexual	married	BA	yes	1	adopted
Judy	57	white	woman	heterosexual	divorced	unknown	yes	2	bio
Katy	29	white	woman	heterosexual	married	BA	no	1	bio
Laura	43	Latina	woman	heterosexual	married	MA	yes	2	bio
Scarlet	26	white	woman	heterosexual	engaged	MA	yes	1	bio
Debra	60	white	woman	heterosexual	married	MA	yes	2	bio
Maddie	25	white	woman	queer	married	unknown	yes	1	bio (ART[1], IUI[2])
Ann	45	white	woman	heterosexual	divorced, partnered	Doctorate	yes	2	bio
Jules	38	Latina	woman	heterosexual	married	MA	yes	1	bio

Mel	37	white	woman	bisexual	married	unknown	no	4	3 bio, 1 adopted
Shayla	37	white	woman	pansexual	married	HS	no; student	5	3 bio, 2 adopted
Heather	33	white	woman	heterosexual	married	unknown	yes	2	bio, twins
Ava	35	white	woman	heterosexual	married	unknown	yes	1	bio
Miranda	35	white	woman	heterosexual	married	unknown	yes	1	bio
Naomi	34	Black	woman	heterosexual	married	MA	yes	3	bio
Trish	38	white	woman	heterosexual	married	BA	yes	2	bio
Isabelle	48	white	woman	bisexual	married	MA	yes	2	twins (egg donation[3])
Jocelynn	50	white	woman	heterosexual	married	Doctorate	yes	1	adopted
Stacey	40	Biracial, Black/white	woman	heterosexual	married	BA	no	2	bio
Cleo	45	white	non-binary	queer	married	Doctorate	yes	2	adopted
Natalie	36	white	woman	pansexual	partnered	HS	yes	4	2 bio, 2 step-children
Tiana	63	white	woman	queer	single	BA	yes	1	bio

Isla	44	white	woman	heterosexual	married	MA	yes	1	bio
Sandra	51	Jewish/white	woman	pansexual	single	MA	yes	2	1 adopted, 1 Gestation surrogate[4]
Rosa	35	white	woman	bisexual/ pansexual	married	BA	yes	2	bio
Teresa	58	white	woman	heterosexual	married	AA	yes	1	bio
Kat	39	white	woman	bisexual	married	Doctorate	yes	1	bio
May	48	white	woman	heterosexual	married	MA	yes	2	bio
Britney	33	white	woman	heterosexual	married	MA	yes	1	bio
Meg	43	Biracial, Asian/white	woman	bisexual	partnered	MA	yes	3	bio
Ronni	28	Latino	man	heterosexual	partnered	MA	yes	1	bio
Alicia	29	white	woman	heterosexual	married	HS	yes	2	bio
Gwynn	36	white	woman	bisexual	partnered	AA	yes	1	bio
Jen	60	Jewish/white	woman	lesbian	single	BA	no	1	bio
Tali	39	white	woman	heterosexual	married	Doctorate	yes	2	bio

Kris	55	white	woman	heterosexual	married	HS	yes	2	bio
Lucy	60	white	woman	heterosexual	married	unknown	no	2	bio
Abby	25	white	woman	bisexual	married	HS	yes	1	bio

[1]Assisted Reproductive Technology
[2]Intrauterine Insemination
[3]When an egg is taken and fertilized in a lab. The resulting embryo is transferred to the recipient's uterus.
[4]Gestatonal surrogate is when an egg is taken and fertilized in a lab and the resulting embryo is transferred to the surrogate's uterus.
[5]Titles of educational degrees have been shortened.

Table 2: Demographic Characteristics

Gender	n
Woman	36
Man	3
Non-binary	1
Race/Ethnicity[1]	
White	34
People of Color	6
Sexuality	
Heterosexual	23
Homosexual	3
Bi/Pan/Queer	14
Education	
High School	7
Associate's	2
Bachelor's	7
Master's	12
Doctorate	5
Unknown	7
Employed	
Yes	33
No	7
Relation[3]	
Biological	34
Adopted	7
ART	3

[1]Combined participants of color into one group because of low sample size. I recognize that these identities are not monolithic and I specify participants' racial and ethnic identities within my analysis.
[2]Combined bisexual, pansexual, and queer because some participants identified as multiple or were sometimes unsure how to initially identify. I recognize that these identities are not monolithic.
[3]Adds up to more than 40 to account for blended families.

Table 1 displays the 40 participants and key characteristics, including age, race and ethnicity, gender, sexuality, relationship status, highest level of education, employment, number of children, and relationship to their children. I chose to highlight how participants became parents, such as being biologically related or through adoption, to compare how body and embodiment may be similar or different across diverse parenting pathways. This is by no means

meant to devalue the relationships between parents and children but to acknowledge how all parents are impacted by hegemonic expectations of the physical body.

Table 2 displays descriptive statistics of the sample. Most of the sample identified as white, cisgender women who conceived, gestated, and gave birth to their children. Just over half of my sample identifies as heterosexual though there is diversity in sexuality. The education of my sample is also markedly high, with 24 participants completing college and 17 continuing on to complete graduate degrees.

Data Analysis

I coded my interviews in waves, allowing for periodic updates to the interview schedule to improve responses and expand on emerging themes. I also emphasized giving participants the chance to guide the interview, sharing what resonated most with them (Compton, Meadow, Schilt 2018). For example, participants would often express feeling insecure or unsure if a story they wanted to share was important. In these instances, I would always reassure them that anything they felt was significant to their experience was significant to the research. After assuring them that they could "go on a tangent," participants would eagerly finish their story. It was these moments that led to me finding many commonalities amongst my participants even if I did not explicitly ask them questions about certain topics initially. These "tangents" helped to inform my interview guide between phase I and phase II.

In addition to analyzing and coding interview transcripts, I also used the notes I took during each interview to further contextualize the interaction. It is important to be aware of our bodies and reactions in relation to our research participants, where facial expression, body language, and other reactions such as laughter can be interpreted in various ways (Compton et al. 2018). This is not meant to suggest that we can adequately control our bodies to be perceived as

"neutral," but rather being more aware of ourselves allows us to "notice and appreciate the moments of ambivalence" (Compton et al. 2018: 133). With this in mind, I have taken notes of pauses, silences, laughter, and changes in volume, pitch, and octave of voice. These act as "field notes" which were incorporated into the interview transcript to better understand how participants are reacting to questions or if I needed to follow-up on a question due to perceived discomfort. I also remained continuously aware of my own reactions and what messages I am silently conveying to my participant.

I also draw from feminist standpoint epistemology to inform my method and methodology (Harding 1987; Hill Collins 2000; Naples 2003; Smith 1989; Sprague 2005; White 2020). While my participants and I hold simultaneous positions of oppression and privilege, I consider primarily my racial and researcher positions, including my position of "expert" due to my education level, of privilege. I also must be transparent with participants that I am not a parent, putting me in a distinct outsider status in this regard. I was aware of the negotiations of insider/outsider status, where I never fully fit in one or the other (Compton et al 2018). It is not enough to simply state our standpoint and must also bring attention to otherwise unmarked categories (Hurtado and Stewart 1997; White 2020). Hurtado and Stewart (1997) suggested a denaturalization of whiteness, where whiteness is also a consistent racializing process. I chose to ask for demographic data after concluding the interview, meaning that I often did not know my participants' race, sexuality, or education status unless these topics came up organically during the interview. During transcription, I paid attention to unmarked categories (such as race, body size, sexuality, gender) to probe further into how participants conceptualize their experiences with medical institutions, family, friends, etc. as parents and how these are also racialized, gendered, and classed experiences. For example, White (2020) sought to highlight the racialized

aspects of whiteness in their study of fat/trans individuals. Most of their participants were white, and while some researchers may have forgone a racial analysis, White (2020) instead chose to highlight the way whiteness was still constructed in a fat/trans narrative as participants often discussed having "bulges in the right places," which were reminiscent of white and middle-class embodiment. If whiteness continues to be unmarked, then we only reaffirm which bodies are deserving of visibility. Paying attention to and questioning these unmarked categories in the moment helped inform my later analysis.

Finally, in regard to a fluctuation of insider/outsider status, I was aware of when to probe for further details in case participants assume my knowledge of a subject. For example, participants sometimes assumed I already knew or thought something specific based on their answers to my questions. Tischner and Malson (2012) explore the way fat women conceptualize themselves as healthy even while adhering to neoliberal and moralizing standards of health, where they agree that fatness is unhealthy but that they themselves are not unhealthy. Tischner and Malson (2012) interrogate the "collective knowingness" about fat as unhealthy, where these connections are often agreed upon but left unspoken. Tischner and Malson (2012) needed to further probe the assumption that they also agreed with these notions and connections of fatness and ill-health. I address the assumed "collective knowingness" when it comes to healthism and fatphobia in relation to parenting by asking parents to further explain their answers. For example, some parents express being concerned with their health through what they consume. Rather than assume I know what they are talking about in relation to eating healthy, I instead ask them to explain what eating healthy means to them and explain that I may have a different idea. With this, parents then have the space to explain what they believe to be healthy eating habits, such as portion sizes, eating organic foods, or refraining from eating foods with certain dyes.

The data include interview transcripts and the "field notes" of the interviews, which are any notes taken during the interview, including nonverbal communication, pauses, and other responses such as laughter. I transcribed the interview and field notes as soon as possible after the interview concluded. I hand coded first, line by line, practicing "open" coding methods, looking for patterns and relevant themes (Charmaz 2014). I then coded and analyzed data while I simultaneously collected data, allowing myself to make changes to the interview schedule as needed as different themes became more prevalent (Charmaz 2014; Compton et al. 2018). I practiced a close reading and re-reading of my interview transcripts to identify dominant themes, following the initial coding with a more detailed analysis of the categorical themes (Tischner and Malson 2012).

Data were analyzed through a discourse analysis, where responses highlight the "historically variable ways of specifying knowledge and truth" (Naples 2004: 28). I look at how values, beliefs, and assumptions are communicated and how these relate to social and historical contexts. Using discourse analysis, I examine participants individually as well as their relations with the discursive construction of medicine, health, fatness, pregnancy, and parenthood in relation to their bodies. By doing this, I aim to simultaneously understand their "identities as multiple, stable, and subject to culture while keeping close to the subjective experience" of individuals (Compton et al. 2018: 10).

Ethical Considerations

To ensure informed consent, I read the information guide and consent form to participants (Appendix E) and asked them three questions: Do you agree that I just read this information to you? Do you agree to participate in this study? Are you at least 18 years old? I would not continue the interview unless the participant answered "yes" to all the above

questions. I did not have to exclude any participants for failure to answer the above questions. I also asked participants if they had any questions before continuing and reiterated that all information is kept confidential and that they may stop the interview at any time. I then asked them if they would like an e-copy or hard copy of the information sheet and consent form before continuing with the interview. Every participant requested an e-copy of the information sheet and consent form. Due to the nature of virtual and phone interviews, I was able to receive verbal consent from participants rather than a signature as per the Institutional Review Board (Appendix A). Participants were reminded throughout the interview that participation is voluntary, that they may skip questions they do not want to answer, request that I stop recording, or stop the interview at any time without penalty.

Ellingson (2017) offers three types of ethical considerations: research purpose, roles/conduct, and representation. The ethics of research refers to the acknowledgment that research is value-laden. However, including instances of embodiment presents the reader with a further understanding of complex relationships, topics, and identities (Ellingson 2017). The incorporation of embodiment highlights "the situated partiality of *all* knowledge claims" (emphasis in original, Ellingson 2017). Situated, often subjugated, knowledge, are not "bias," but instead intriguing sites to explore what we think we know (Ellingson 2017; Collins 2000). Therefore, I also practiced reflexivity and explore my own biases to check my own assumptions of knowledge production. However, in line with Compton et al. (2018), there is also the necessity to grapple with what we *think* we understand. I attempted to maintain an ethical consideration when signaling my assumed belongingness to a group. In other words, it is dangerous to make the claim that I understand all of my participants' experiences, regardless of the kinds of backgrounds we share together. While there is the possibility of building rapport, it

can also severely limit what they are willing to share, either because they think I already understand, or worse, their perception of my understanding comes off as disingenuous due to our difference (Compton et al. 2018). Ethics of representation is also important to consider. Ultimately, the researcher has the power to choose which words and moments are highlighted. It is the researcher's responsibility to control the way we "inevitably speak for others," especially when we hold various positions of privilege (Ellingson 2017; Brown and Herndon 2020).

Other ethical considerations concern the subject matter of the study. I will be speaking with individuals who have presumably experienced structural and interpersonal violence while in the process of becoming parents (McPhail et al 2016; Roberts 2017; McPhail and Mazur 2020; Lee 2020). This violence is incredibly traumatizing as bodies are tightly regulated, dehumanized, controlled, and blamed. Parenthood is also challenging, and parents experience many external and internal pressures to be the best and most "appropriate" parent based on idealistic and unrealistic expectations. The topic of parenthood experiences will be an extremely sensitive topic that will need to be considered with care and compassion.

I considered participants' caretaking responsibilities and offered flexible interview times. I also took into account having the children in the space, as it can go a long way in making children feel welcome and assuring parents that they do not have to come up with childcare to participate. During interviews, I let parents know that they can stop the interview at any time for any reason. Participants sometimes needed to stop the interview to care for children, especially if children are home, but all participants who had to end their interviews early were willing to schedule a follow-up interview. Providing this flexibility helped to build rapport and assure participants did not feel pressured to have to choose between parental duties or continuing the interview.

Finally, there has to be ethical considerations regarding privilege and power. I interviewed individuals who were quite different from me. While I consider myself fat, I am also white, a graduate student, cisgender, and while identifying and often presenting as queer, have certain privileges of being in a relationship with a cisgender man.

CHAPTER 4

BODY BEFORE BABY

The transition to parenthood, especially for gestational parents, is marked by changes in physiology, anatomy, and hormones. Researchers have also found that fathers experience similar physiological changes as mothers, such as increased serotonin and weight gain when their partners are pregnant (Laroche et al. 2013; Brown et al. 2017). Though there are many physical changes when one becomes a parent, the transition to parenthood is also social. Expectant parents, through various social messaging regard health as capital (Boero 2009; Edvardsson et al. 2011), recognize the importance of presenting as health conscious for themselves and their future children. However, due to changes in body shape and size during pregnancy in particular, which are expected to some extent (CDC 2022), expectant parents may find that their changing perceptions of their bodies challenge normalized expectations, such as attempting to maintain or lose weight.

I find two main themes regarding parents' perception of their changing bodies and embodiment in relation to their transition into parenthood: weight gain messages and the importance of body shape. First, I find that messages of weight gain are contextual and complex. Messages of weight gain are framed differently among participants. Messages of weight gain during the transition of pregnancy can be categorized as expected and accepted, granting a reprieve from expectations of thinness to expectant parents, or as stigmatized and moralized, resulting in persistent weight loss messages. I examine participant responses indicating messages parents receive about weight gain while becoming a parent. I find that some parents conceptualize weight gain and parenthood as potential reprieve from weight loss or weight maintenance expectations. On the other hand, parents who were previously fat or gained more

weight than expected during pregnancy instead experience more of a persistence of weight stigma rather than reprieve.

Second, I find that parents not only worry about how much they weigh or how much weight they have gained, but also how the weight is distributed on their body and expectations regarding the shape of the parenting body. Participants are not only concerned with weight gain but also the "shape" of "excessive" weight on the body. Larger or chubby bodies are more acceptable if their bodies remain "proportional," such as maintaining a clear hourglass figure and not gaining excessive weight in their arms, legs, and face.

My findings indicate that parents have a complex relationship with their weight prior to becoming a parent. Not only do they contend with anti-fat messaging through general socialization and historical contexts but also messaging from others who may construct them as inherently unfit parents. Parenthood offers a sense of reprieve for some parents, allowing them opportunity to gain weight, but these parents also express concern regarding weight gain. Other parents are not offered the same reprieve and instead must further advocate for themselves to receive resources related to family planning despite their weight.

Weight is also more contextual than just the number on the scale. Kyrölä and Harjunen (2017) theorize what they call "liminal fat," a categorization which defines fat as a constant threat, where individuals must always be working toward removing or preventing excess fat. My participants, however, are not always concerned with fat in general, or weight overall, and instead worry more about their body distribution and proportion. Considering liminal fat, or the potential to become fat, fatness is also how weight sits on the body. Some parents who become pregnant appreciate their bellies more than those who do not "show" in ways they expected and express concern over gaining weight in places besides their breasts and buttock. While weight

gain is expected to some extent for gestational parents, and to a lesser extent for fathers and non-gestational parents, there is still a fear of becoming *too* fat and worrying about the ability to lose the weight after giving birth. However, expected weight gain in the transition to parenthood is often narrow. Normalized weight gain during pregnancy, for example, is based on current BMI, number of fetuses (single, twins, etc.), and often at the discretion of the medical provider. With this in mind, parents must navigate often competing and complex messages about their weight gain as they transition into parenthood.

I now move on to discuss how messages of weight gain in the transition to parenthood is characterized differently for parents in normative versus non-normative bodies, specifically focusing on weight and size. I then describe how the shape of parenting bodies is an important consideration for examining messages of weight gain. I conclude by bringing together the importance of body weight and shape and how these impact social pathways in parenthood.

Messages of Weight Gain Approval and Stigma in the Transition to Parenthood

Body weight in the transition to parenthood is important, especially within medical institutions. Higher body weight among gestational parents is often thought to correlate to negative birth outcomes, such as higher weight babies, gestational diabetes, increased need for C-sections, and increased rates of infertility (Averett and Fletcher 2016; Sole-Smith 2019). Body weight, specifically BMI categories, are also used by assisted reproductive technology (ART) providers, where many will not accept patients in the overweight and obese BMI category (Sole-Smith 2019; Shaw and Fehoko 2022).

My results show that parents navigate messages of weight gain to varying degrees and they often refer to both body weight and shape as important signifiers for their perceptions of positive and negative birth outcomes. In this subsection, I describe two different responses:

weight gain reprieve and weight loss persistence. Parents who describe themselves as thin or average-sized prior to becoming a parent reported that weight gain was encouraged or generally not a worry for them or their healthcare provider. Instead, weight gain, during pregnancy specifically, was seen as an opportunity to "let go" of traditional expectations of thinness, which was not the same for fat parents.

Parents who identified as overweight, plus-size, or fat prior to becoming a parent reported that weight gain was more central to their ability to become a parent because of various institutional and interpersonal barriers. Fat parents reported additional stigma directed toward them by healthcare providers and social workers because of their larger bodies.

Parents who describe themselves as thin, average-sized, or "athletic" are more likely to embrace physical changes and acceptance of weight gain during parenthood, internalizing a belief in relaxed hegemonic beauty standards. However, they acknowledge the impossibility of maintaining these standards as societal norms reassert themselves after having children. In contrast, fat parents, having already deviated from conventional beauty standards, lack the opportunity for reprieve. I discuss how fat parents respond to this lack of reprieve in more detail in Chapter 6. While thin and average-sized parents may enjoy a perceived reprieve due to their prior conformity to societal expectations, fat parents face continued scrutiny and denial of services needed for expanding their family, exacerbating the challenges they encounter.

"I Knew I Was Gonna Get Fat and Happy": Weight Gain Reprieve

Body weight and size are an important cultural signifier in the United States. Normalized body weight and size expectations impact individuals of all genders, race, socioeconomic status, and ability (Aphramor 2009; Saguy 2013; Sanders 2019; Strings 2019; Austen et al. 2020; White 2020). In particular, body weight and size is surveilled and racialized

in relation to gendered expectations of femininity, particularly white, hegemonic femininity (Strings 2019). Additionally, research on rites of passage and transitions into parenthood articulate motherhood as the ultimate portrayal of femininity (van Gennep 2019). In other words, the transition into motherhood can enable women to forgo previous expectations of the aesthetics of femininity, especially thinness, *because* of their transition into motherhood. Through engaging in prospective motherhood, especially during gestational pregnancies, women are afforded somewhat of a reprieve from weight gain expectations, allowing them to challenge expectations of diet culture and freely gain weight.

Parents, particularly gestational mothers, who describe themselves as "thin" or "average" sized, meaning they do not see themselves as overweight, regardless of their actual measurements within the BMI, responded with mixed experiences about their bodies before becoming pregnant and after becoming parents. However, during their pregnancies, thin and average size mothers generally found a type of freedom in being able to gain weight precisely because they were pregnant. Self-described average sized parents mentioned occasionally feeling as if their weight was being judged by healthcare professionals in particular, but primarily report that it was expected they will gain some weight or were encouraged to gain weight to help with gestation or breast feeding, directly challenging expectations of feminine thinness in favor of feminine expectations of nurturing children.

Participants who described themselves as thin or average size before and during their pregnancy note that weight gain was discussed as an expectation by doctors and reflected on feelings of being able to "let go" during their pregnancies. Previous research suggests that pregnancy is often used as an "excuse" to gain weight, especially for expectant mothers rather than as a time to consider managing their weight (Furness et al. 2011). Furness et al. 2011

construct weight gain during pregnancy as potentially irresponsible, claiming that women are using pregnancy as an "excuse" to gain weight, supporting narratives that gaining weight is akin to not taking care of oneself. Mothers who gain weight during pregnancy, then, are seen as potentially irresponsible in accordance with healthist and neoliberal goals and ideologies of individual responsibility, such as being seen as unable to care for one's health. However, my participants do not view their choices and experiences as simply an "excuse" to gain weight but rather an opportunity to reclaim a sense of bodily autonomy and joy and to have a moment in rejecting gendered expectations of femininity. While Furness and colleagues (2011) construct pregnancy as an excuse to ignore the supposed pitfalls of weight gain during pregnancy, my thinner participants, exemplified by Rosa and Kris, both white, average-sized mothers, reported feelings of reprieve from social and gendered expectations of the body, especially for gestational mothers:

> Rosa: I cared a lot less about my diet when I was pregnant, which led to quite a bit of weight gain… It felt good to just let go and not worry about it.
>
> Kris: I knew I was gonna get fat and happy, and I was good with that.

In this instance, the transition to parenthood is an embodied experience which brings together the physical and social. Parents who described themselves as thin or average size see their transition into parenthood as a status which can challenges physical and social norms of women. While these participants see themselves as challenging feminine expectations, specifically through gaining weight and feeling at ease, or even happy, with it, previous research has suggested that this reprieve comes from enacting the ultimate act of womanhood, becoming a mother. Through successfully encapsulating womanhood, and also adulthood, through pregnancy, my participants show that women who become pregnant may be given

more opportunities to “let go” when concerning weight gain and see this as an opportunity rather than an excuse.

The act of “letting go” during pregnancy is viewed by some as liberating but is simultaneously fraught, moralized, and constructed along an arbitrary timeline. Many participants are also quick to explain why “letting go” during pregnancy is not necessarily a “good” thing, and that they were in the process of attempting to lose the “baby weight” soon after giving birth. Thin and average sized parents also contend with internal feelings of anti-fat stigma rather than explicit and external messages, reporting a worry about maintaining their pregnancy weight gain for too long after they have given birth. After Rosa, who identifies herself as thin prior to becoming pregnant, explains that she felt good not worrying so much about restricting food, she quickly followed up with, “but obviously, that’s not the best approach to take either.” In this instance, Rosa and Kris express appreciation for being able to reject societal standards of thinness but Rosa also makes sure to note that eating and gaining weight is not a *good*, in other words, moral, approach. Rosa inadvertently moralizes her good feelings associated with “letting go” and gaining weight. Rosa recognizes that once she was no longer pregnant, she would need to rely more on the social capital that comes with normalized body expectations of thinness and perceived health. However, the expectation of the normalized body size and shape for men and women is constructed through social channels of normality and guidelines created by medical professionals. How and when these guidelines are used by medical professionals in informed by social norms of weight and health. Therefore, these guidelines can be used to expand or restrict access to resources and reinforce stigma.

Expectations of weight gain for gestational parents, as noted by the Center for Disease Control and Prevention (CDC) (CDC 2022), are based on the BMI criteria. The expected norm

for weight gain, as stated by health care professionals, was often different than what my participants expected. My participants, who spoke explicitly about weight gain, mentioned a range of 25-30 pounds as the "norm" for weight gain during pregnancy, regardless of their self-described body size. According to the CDC (2022), the expected weight gain for pregnancy is calculated based on their BMI rather than a standard amount across all individuals. For example, those in a "normal weight" range, with a BMI of 18.5-24.9, "should" gain 25-35 pounds throughout their pregnancy. This goes down to only 11-20 pounds for an obese person, someone with a BMI equal to or greater than 30. This means that a five-foot, four-inch woman who weighs 174 pounds would be considered obese and would be expected to only gain 11-20 pounds during her pregnancy. The CDC (2021; 2023) also reports that the average adult weight of a five-foot, four-inch American woman, as of 2021, is 170 pounds, putting them right on the line of the obese category. While mothers may be offered some reprieve regarding weight gain, medical institutions and messaging constrict the amount of weight women "should" gain based on a measurement which does not effectively measure health or potential health outcome. Women who are the "average" weight in America are then stigmatized based on a calculation that does not take other factors into account when considering positive pregnancy outcomes. In other words, women with a statistically normal body are treated as abnormal. While this does not disregard the stigma and discrimination faced by fat individuals, it is important to note how abnormality is socially constructed against statistical normality, which can exacerbate stigma and discrimination when medical providers or social workers may haphazardly choose when and how to implement guidelines.

Laura, a thin, Latina mother, discusses her frustration with her doctors after she was told she was gaining too much weight with her second child based on general recommended

guidelines. Laura said she did not worry about her weight throughout her second pregnancy after gaining 70 pounds during her first pregnancy and 40 pounds with her second. Laura recalls doctors commenting on her weight gain and her body throughout both of her pregnancies because her weight gain was well about the "average" expected weight gain for someone pregnant with a single baby. While Laura received negative messages about her body from her doctor, she felt that her weight gain, especially with her second pregnancy, was not a concern and felt frustrated that her doctors continued to focus on it. Laura recalled when she went to her first appointment with a new doctor while she was pregnant with her second child, she says:

> I went to my first appointment, and the first thing he did, before he even looked at me, was told me that I needed to not gain any more weight. And I'm so pissed, because with [my first pregnancy], I gained 70 pounds, and a good portion of it in the beginning. And with [my second pregnancy], I had only gained like 40 pounds. And he was like. 'you need to not gain any more weight.' And I was like, 'actually, I've only gained 40 pounds, and I gained 70 with the last one. So I think I'm doing pretty good.' And he was all 'Oh, oh, yes. I see that. Now that I see that. Yeah, okay. Very good.' And right at that moment, I am thinking, I can't even trust you to read the chart to see anything, the first thing he said to me before he even looked at me was I should not gain any more weight, and I'm supposed to trust him to go through labor?

While Laura experienced a negative interaction with her doctor, she continued to challenge the idealized notions of weight gain during pregnancy. However, Laura does compare her first and second pregnancies, where her 40-pound weight gain during her second pregnancy is seen as more acceptable to her because it was not as much as the 70 pounds she gained during her first

pregnancy. Regardless, Laura, like Rosa and Kris before, challenge individual, interpersonal, and institutional, weight expectations and messaging to women by highlighting their positive relationship to their weight gain during their pregnancies, such as enjoying being able to gain weight and not worrying about losing the weight immediately.

Rosa, Kris, and Laura challenged the expectations of weight gain stigma and found their transitions into motherhood as an opportunity to have a different embodied experience outside of normative weight loss or weight maintenance even when presented with internal and external pressures to lose or maintain their weight. While my participants often echoed a generally expected 25–30-pound weight gain during pregnancy, this range only accounts for single pregnancies, not when one is pregnant with multiples.

In addition to weight gain recommendations being utilized in problematic ways, much of the information given to gestational parents only accounts for a single pregnancy. The recommended weight gain charts from the CDC (2022) also stipulate differences for weight gain based on the number of children one is pregnant with, where a "normal weight" woman would be expected to gain between 37-54 pounds if pregnant with twins. This information is not always clearly shared with patients, meaning that those who are pregnant with twins may experience more internal and external pressure to lose or maintain their weight than those who are pregnant with single babies. This was a realization for Isabelle, a thin, white mother, who, during her doctor's appointments, noticed she was only given charts and information for single pregnancies, not those with twins:

> I remember, [the doctor] would give me the weight chart and it was for carrying a single baby. I remember thinking like, with twins, it's a little different because

> I got two little bugs in there. My memory of [my visits] is very much that I was gaining too much weight, that was the message.

Isabelle, who describes herself as thin or average size, continues to describe the focus on her weight, highlighting that she felt there was little recognition that she was carrying twins. When I asked if she had any concerns physically about her pregnancy, she says, "you know, I didn't at first, but then it really escalated, and I don't know if escalated is the right word, but I probably should have been in the [doctor's] office more, my memory is just a lot of focus on my weight, concerns about my weight." Isabelle recognized that she did not really have concerns about her weight until she felt she was *supposed* to through interactions with her doctor. In other words, her pregnancy was a time of *expected* weight gain that she was not worried about until her doctor made her feel like she needed to be concerned.

Isabelle became worried about weight gain but also about the inaccuracies of the charts she was given about weight gain. She began to question her doctor's concern when she realized the information she was receiving about weight gain during pregnancy did not match her pregnancy, "them saying I was gaining weight, but I think this was normal for a pregnancy like mine," specifically being given charts with single pregnancies rather than twins, which would have shown about a 20 pound weight gain difference. In this instance, Isabelle felt she needed to worry about her weight only because her doctor made her feel like she had to through the constant reminders that she was gaining too much weight. However, her weight gain was only considered "too much" when compared with a single pregnancy, not with twins. Isabelle's experience highlights how, individually, participants who are pregnant are often not concerned with their weight until they are told they should be, either through external channels, like Laura, or internal, like Rosa.

My participants, particularly thin and average-sized participants, reflect on feeling reprieve from body weight expectations even if they gained weight above the recommended CDC (2022) guidelines. For some, however, becoming a parent, especially becoming pregnant, meant they were able to "let go" of some of the societal expectations related to weight gain, perceiving pregnancy as a sort of reprieve from idealized thinness. Such as with Kris above who stated they knew they were going to be "fat and happy," where being able to eat and gain weight without the pressures of having to maintain or lose weight.

Pregnancy, in these instances, provided an avenue in which parents can, in some cases, enjoy gaining weight or can at least shift their expectations about weight gain. At the same time, there was recognition, for example from Rosa, who showed that this reprieve would not last forever. Parents like Isabelle had concerns about weight gain only when it was brought up by her doctor, but then shifted to feeling like she should have had *more* leeway for weight gain because of being pregnant with twins. While the parents described above reported reduced anxiety about weight gain in the transition to parenthood, others experience increased weight loss messaging linked to their transition to parenthood, especially if they do not conform to previous expectations of thinness.

"They Were Worried I Was too Out of Shape to be a Parent": Weight Loss Persistence

Persistent weight loss messages were also common through participants' transition to parenthood. Those with smaller body sizes, perceived to be within "normal" BMI ranges, are often thought to also be healthier because of the assumed connection between higher weight and health problems like hypertension and diabetes. However, research has found contradictory outcomes relating to higher weight and pregnancy, usually defined as a mother with "obesity,"

and birth experiences, including potentially longer times to become pregnant, rates of stillbirth, and the need for C-sections and inductions (Law, Maclehose, and Longnecker 2007; Han et al. 2011; Sole-Smith 2019). Differences in time to pregnancy, while statistically significant, only account for about a one-to-two-month difference between average-sized and "overweight" or "obese" women (Law et al. 2007). Rates of stillbirth are found to be up to twofold more likely for obese women, but the event of a stillbirth is still rare. Stillbirths, for the general population, are five in 1,000 births compared to seven to ten in 1,000 births for obese women (Carmichael et al. 2015). While it can be argued that obesity may have an increased risk of stillbirth, Washington-Cole and colleagues (2017) find that overweight and obese mothers are asked fewer questions about their pregnancies and lifestyles by their healthcare providers and are generally given worse treatment than their thin counterparts. In this case, the increased risk of stillbirth for fat women may be social rather than biological. Fat women may have higher rates of stillbirth simply because fetus anomalies are not caught earlier rather than obesity being the reason for increased stillbirths. Additionally, while fat women are often told by doctors they will need to be induced or have C-sections, research has shown that many women may not be given the chance to attempt a vaginal birth, instead being told that, because of their weight, a vaginal birth could be dangerous for them and their unborn baby (Lee 2020). Finally, higher weight is also often associated with unhealthy lifestyles and behaviors which directly challenges perceptions of someone as being a "good" and "fit" parent, and may result in poorer quality treatment (Boero 2009; Mulherin et al. 2013; Boero and Thomas 2016).

Participants, even when recalling a reprieve from weight loss expectations, described messages of weight loss as prominent in their transition to parenthood. As Rosa, a self-described averaged-sized woman, said earlier, while she appreciated "letting go," she

recognized that eating whatever she wanted was not "good." Additionally, a thin white mother, Katy, expressed her discomfort with only being able to "stomach carbs" during her pregnancy due to extreme nausea, because carbs are a food commonly associated with weight gain. She also lamented the fact that her desires to exercise and "eat really well" during her pregnancy were complicated by only being able to eat carbs saying it "was a little disappointing." Diet messages often associate carbs with "bad" foods that lead to weight gain. She went on to explain that she gained 50 pounds during her pregnancy and maintained that weight gain six months after her son was born.

> So I didn't lose anything having him, in the moment it didn't bother me. But I could tell it was affecting how I walked, my knees were hurting, I didn't feel comfortable in my clothes and I was wearing my husband's clothes all the time. So physically, you know, gained a lot of weight and had a hard time being okay with that.

Laura also shows the ways in which participants can simultaneously challenge and support normative body expectations regarding size and shape. I previously discussed Laura's experience with her doctor, where she challenged her doctor's assumptions about her health and weight when she gained 40 pounds during her second pregnancy. While Laura, during our interview, expressed frustration about the doctor focusing on her weight gain and not actually communicating with her or effectively reading her chart, she explains that her weight gain is not "bad" because she gained more with her first pregnancy. Laura challenged anti-fat and anti-weight gain stigma by realizing the doctor was potentially not going to adequately care for her if he only noticed her weight gain and also reaffirms perspectives that weight is a moral characteristic. Laura identifies issues with her doctor "not even looking" at her before

commenting on her weight gain, ignoring her as a person. Laura then decided to find a new doctor, stating her lack of trust for a doctor that, she perceived, as unable to see her as a whole person. While Laura recognized issues with her doctor focusing on her weight, she also expressed that she was "doing pretty good" because she did not gain as much weight with her second pregnancy as with her first. Laura is presenting herself as distanced from others, or even her past self, who are perceived to have gained too much weight. Regardless of her own positioning and relation to her own weight gain, Laura's decision to change doctors is a way of resisting anti-fat stigma and advocating for herself despite messages about weight gain.

Through the examples of Rosa, Laura, and Kris, I find that participants who identified as thin or average-sized, received messages of weight stigma from their health care providers and from general social messaging in which they internalize. They, however, were also able to better position themselves to challenge instances of weight stigma before and during their transition into parenthood, unlike parents who identify as fat, overweight, or obese during their transition to parenthood.

Fat parents, on the other hand, regularly called back to clear moments in their childhood when they were first taught their bodies were considered problematic which has now followed them into adulthood and parenthood. Tiana, a self-described super fat white woman, says she has felt "pretty consistently oppressed" due to her size, recalling, "I was put on my first weight loss diet when I was seven, when I was nine, the doctor said 'take off all your clothes and bend down and touch your toes, so I can see how fat you are.'" She continues, saying it was "trauma, trauma, trauma, around weight stuff and being judged, and that hasn't changed." Tiana described her experience with her weight as traumatic and starting at an extremely early age. While she stopped engaging in intentional weight loss in her 20s, she is now in her 60s, her weight has been

a site of trauma, especially when engaging with medical professionals. Many participants located issues with their weight specifically on medical professionals, feeling that many doctors did not take a holistic view of them as patients, reducing them to their weight and BMI, particularly in relation to them becoming parents.

While thin parents reported having some issues with their weight gain, fat or overweight parents were called into question about their ability to conceive or raise children. In order to show they were "good" and "fit" parents, despite their weight, my participants often shared the different ways they attempted to receive care related to growing their family, including parents who became pregnant, adopted, or attempted reproductive technologies such as IVF and IUIs. Fat parents experienced persistent messages about their weight which implied they would not be able to conceive or may not be able to effectively raise their children. Research finds that fat mothers in particular are denied access to reproductive technologies and treatments because of their weight being linked to unhealthy lifestyles, inability to effectively play with their children, or assumptions about their ability to become pregnant and carry a pregnancy to term (Boero 2009; Sole-Smith 2019; Lee 2020; Basinger, Quinlan, and Curry 2024).

Participants who described themselves as fat, overweight, or plus size, find that institutional actors through medical and social service institutions are barriers to receiving adequate care for expanding one's family. Naomi, a fat Black woman, experienced negative interactions with those who were responsible for her care in her various pathways to parenthood. When I asked her about her experiences with her doctors she said, "at first I didn't have a good experience because most of them were blaming me for being overweight and that I should lose weight to get pregnant." Naomi had been trying to conceive for some time prior to finally getting pregnant. She explained that she had issues with cysts on her ovaries but doctors

insisted that if she just lost weight, she would eventually conceive, “I tried to lose weight,” she says, “but it was hard. Seriously, I didn’t lose weight, I didn’t lose weight. [When] you’re seeking to become pregnant, you’re stressed, and when you’re stressed, it’s even harder to lose weight.” Research has shown that one in four women struggle to get pregnant (CDC 2022) and that infertility involves emotional and psychological burdens (Johnson et al. 2020; Palmer-Wackerly and Krieger 2015). Naomi attempted to receive fertility care and advocate to get a surgery that would remove the cysts from her ovaries but was instead met with additional barriers which added to her overall stress. She did finally find a doctor willing to do the surgery, “I fought for getting us to conceive, and [this doctor] was very good. He advised me on a lot of things, including the surgery, and then after that is when I conceived.” Naomi had to change doctors multiple times before finding a doctor that would listen to her needs and help her beyond telling her to lose weight.

Naomi’s experiences echo those in other research, where fat mothers are not afforded the initial care to necessitate adequate or positive experiences with their health care providers (Mulherin et al. 2013; McPhail et al. 2016; Lee 2020; Shaw and Fehoko 2022; Basinger et al. 2024). Additionally, consistent and maintained weight loss, even with medical interventions such as surgery, show a general five-to-ten-pound weight loss with many individuals gaining it back over the next 5 years (Sole-Smith 2018). Naomi being told to just lose weight was not an effective treatment for infertility.

Daniel, a fat white man, who adopted his son, reflected on the process he and his thinner husband had to go through in order to be approved as foster parents. Daniel and his husband had to complete various evaluations, primarily psychological, to ensure they were prepared to raise children. While state sanctioned evaluations of psychological wellbeing can be

problematic, Daniel had to also undergo additional tests to ensure he was physically fit enough to carry a baby or play. He says,

> I am a beefy guy, I'm a fat guy. I remember, it was so dumb, being told that I had to, during my physical, make sure that I could lift 10 to 15 pounds for a short period of time. As a fat person, okay, make sure that I would be able to care for a child. Because they were worried I was too out of shape to be a parent. [My husband] and I were like, 'are you serious? This is what you're worried about?' The straights can just, you know, have a baby, but I've got to make sure that I can hold a sack of potatoes essentially for like, 30 minutes.

Daniel expressed his frustration about a physical test he was required to take that his thin husband did not have to. At the end of his statement, Daniel roots his frustration in the fact that he had to undergo additional surveillance to be approved to parent because he cannot biologically have a child with his husband, claiming that cisgender, heterosexual couples, "the straights," must have it easier. However, his initial discomfort is because the test was expected of him because of his weight, not necessarily his sexuality. It is unclear if fat, cisgender and heterosexual individuals had to undergo the same evaluation, but Daniel's thin husband was not expected to participate in any fitness tests.

Participants such as Rosa and Katy, who both lament their weight gain but do not consider themselves fat, did not receive overt messages about their bodies or weight gain from medical providers prior to becoming parents. Their expectations of weight were more positive during their pregnancy, where Rosa was able to "let go" and Katy says the weight gain did not bother her until she was six months postpartum and still had not lost any weight. Daniel and Naomi, on the other hand, struggled to even receive family planning care and access initially

because of their weight. While sexuality and race can contribute to barriers in family planning and access to medical resources, it is noteworthy that neither Daniel nor Naomi rooted their experience in these aspects of their identities. Instead, they saw their weight as the salient factor in their embodied pathways to parenthood. Rosa and Katy, as parents who did not care too much about their weight during pregnancy, responded that, at some point, they would need to care for their weight gain, embodying another transitional period of parenthood, where the weight is lost and they can once again conform to adequate expectations of femininity.

"I Wasn't Looking Pregnant the Way that They Were Looking Pregnant…": Shaping the Parenting Body

The shape that weight takes on the body is also an important factor for how individuals respond to their changing bodies, such as "looking pregnant" rather than fat. The way fat is presented on the body is just as important, if not more so, than the actual weight of a person. For example, some fat individuals may find they are "proportional" or have more of an "hour glass" shape compared to others who may be rounder in their stomach and have thinner legs. Additionally, euphemisms such as "bingo wings" (upper arm fat), "double-chin" (fat below the chin or on the neck), "dump truck," (a large buttock), "fupa," (fat on the vulva),"man boobs," (fat on the breast tissue of men), and "beer bellies," (fat accumulated on the mid-section, usually associated with men) highlight how we speak about fat body parts as particularly undesirable. Body shapes are also given names, such as "apple" to refer to someone with a large or round midsection and skinny legs, or "pear," someone who has fat hips and thighs but a small torso.

The shape of weight on the female body can be drastically different than the shape of weight on male bodies. Norms of feminine beauty are tightly linked to European beauty

standards, such as being white, small, and petite (Schippers 2007; Strings 2019). Men, on the other hand, are expected to be more muscular and taller in accordance with hegemonic masculinity (Connel and Messerschmidt 2005; Whitesel 2014). Fat men and women, especially in consideration for how their weight "sits" on their bodies, may have their gender identity and sexuality threatened because of their failure to adhere to normative expectations of body size (Whitesel 2014; White 2020). For example, fat women are often denied access to femininity which is also rooted in heteronormativity, where fat women are related to non-normative gender expectations and sexualities (Tischner and Malson 2011). Men, on the other hand, have their own standards of masculinity, but also have somewhat more leeway. For example, the concept of the "dad bod" in recent years has invigorated an attraction to men who "look like a dad," such as having beer bellies. Additionally, fat men in gay spaces contend with both heightened masculinity and challenges to it (Whitesel 2014). However, bellies and breasts on men also frame them as feminine, due to softness being associated with nurturing and parenting and also grotesque when seen on men (Monaghan and Hardey 2011). However, beauty standards have shifted in the 2010s and 2020s away from the extreme thinness of the 1990s. Plastic surgery has provided an avenue for women to sculpt their bodies to the extreme, accentuating their breasts and buttocks while simultaneously maintaining a flat stomach, a look which is, in reality, impossible to achieve for the vast majority of women without medical intervention. Women and men are bombarded with expectations of what bodies *should* look like rather than what is actually attainable. However, as noted previously, becoming a parent offers some leeway into how parents, especially women, are able to "let go" while they are pregnant.

While weight gain may be expected, and sometimes even encouraged, the way the weight sits on the body is another important factor. For example, Lee (2020), a fat scholar

writing about her pregnancy, explains how she always had a "double stomach" and did not look pregnant until the eighth month of pregnancy. Additionally, even when she felt she "looked" pregnant, she never developed the perfectly round shape of pregnant women shown in the media.

Many participants found weight fluctuations to be exciting specifically because of the opportunity to look pregnant. Abby, a small fat white woman, actually lost weight during her first trimester and says "I started to get rounder, I got cuter and rounder." Abby recalled her body before having children, saying she felt confident because she felt "proportionate." When I asked her to elaborate, she said:

> like, I don't know… like, there was, there was not stretch marks, there was not that little pouch you get when you have a baby. Like, I may have been a bit bigger, but like, [my stomach] was flat, like I could see all the way down, you know? But since having a baby, it's… there's definitely a pooch there. And my boobs are definitely so huge and they sag now."

Abby struggled initially to convey her confidence in her body through her description of "proportionate," ultimately deciding that it meant she would be considered "bigger" than average but still have a flat stomach and large breasts, evoking an image of an hourglass figure. Again, Abby was not so much concerned about her weight as much as how the weight was distributed before and after having children, where she now has a "pooch" on her lower stomach and saggy breasts.

Gestational parents who were thin or average sized when they conceived were generally excited about getting "rounder" and "cuter." While roundness or plumpness is usually associated with cuteness in relation to small children, becoming pregnant gives some parents an

opportunity to feel good about gaining weight. For example, Kris said she knew she was going to be "fat and happy" which adheres to stereotypes of fatness as sometimes connected to characteristics of joviality and cheerfulness, and alternatively framing thinness as associated with restriction and sadness. However, these feelings are complex, especially when participants go through identity shifts related to parenthood, especially different gender expectations.

Abby and Ronni, while not the only parents to express negative feelings about their changing bodies, were two that explicitly evoked the concept of the "mom bod" and "dad bod." Here, Abby describes her mom bod:

> I would describe myself as like a total mom bod, very frumpy and short, like, I need to work out… I kind of hate my body right now, I'm the heaviest I have been in a really long time, like 230 pounds now. I am just like, worried that it's gonna keep going up… For the mom bod, it's just like, it's just, you know, it's, I mean, I'm sure, so I said short, but, but, you know, the, the poofy belly, you know, the double chin, I mean, I guess, obviously not all women even get a mom body, some have five children and not look like they have a mom bod.

Abby frames a "mom bod" as negative, even going so far as to say that not all moms have a mom bod, in other words, do not look like they have or had children. Abby, while easily using the image of the "mom bod," or of a mom who looks frumpy and not "put together" also struggled to clearly describe what someone with a mom bod would look like overall, frequently pausing during her description. Additionally, while Abby described her weight in relation to her perspective of herself having a "mom bod" she also went on to describe the *features* of weight gain, or the "shapes" of a body that are undesirable, particularly having "poofy" stomachs and "double chins."

Ronni, a thin Latino father, highlighted important considerations for how mothers and fathers are seen differently. He makes the connection between bodies and parenthood beyond the understanding of who is capable of becoming pregnant. Ronni initially expressed that he does not feel like his body has ever really explicitly been judged before or after becoming a parent, and if it ever did, he does not think it was "viciously or frequently" adding, "I think, I think most males would say 'no'" suggesting that body shame is mainly a woman's issue. However, as the interview continued, Ronni began to express his feeling regarding the "dad bod," saying:

> Ronni: I do occasionally get, like, the excuse. So, like, I'm decently in okay shape, you know, very average American. I'm fine, not like a supermodel, like if I go to the beach, I'm not amazing looking, but I get the excuse that it's like, it's the thing called the dad bod, right? So, a lot of my friends are just like, 'oh, yeah, you can eat that extra cheeseburger, you're fine, you're fine, don't worry," so, okay, it's like a 'get out of jail free' card in a way, like, 'nah, you can look bad if you want to.
>
> Torisha: How do you feel about this idea that you can have an extra cheeseburger because you're a dad?
>
> Ronni: First of all, so, in my brain, the ideal dad bod is kinda busted, okay, like to keep the bod, you know, you've got a little fat in the tummy area, but got really big arms, like, a nice chest, and just super hair, just hair everywhere. And, oh man, I can't grow hair, like, I can't get a beard, or any of that. So, I am always, just, I can't get there, like it's not a thing I can do.

Ronni describes the ideal dad bod as "busted" because there seems to be very explicit expectations of who can achieve and maintain a dad bod, a type of body that Ronni himself does not think he can achieve. One particular difference between Ronni's definition of the dad bod and Abby's definition of the mom bod is that dad bods are more forgivable and may even be aspirational, as Ronni says you need to have a "nice chest" and a hairy body, body attributes he feels he cannot achieve naturally. Abby, on the other hand, describes the weight gain associated with the mom bod, specifically if that weight leads to "poofy" stomachs and double chins, as something to avoid. While both social constructions of the mom and dad bod include weight gain and various bodily changes, dad bods are framed as more positive compared to mom bods showing gendered expectations of body size and shape.

Gestational parents who describe themselves as curvy, fat, or overweight do not always look the way they expected to look while pregnant. The stereotypical image of a pregnant woman is one who is svelte, lean, and with a perfectly round belly. One participant, Lucy, a thin white woman, evoked the famous image of Demi Moore on the cover of Vanity Fair in August 1991, where she posed nude in profile toward the end of her pregnancy, prominently displaying her large belly, as shown in Figure 1.

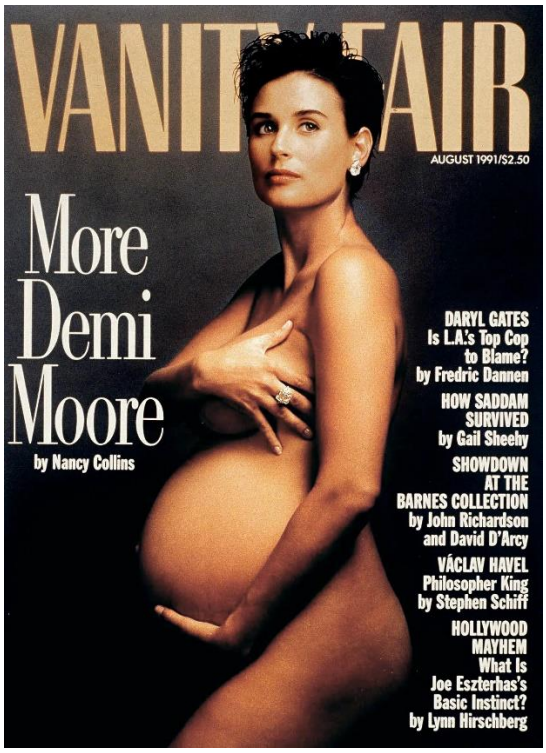

Figure 1: Demi Moore, pregnant, in profile on the cover of Vanity Fair

Images like these are presented as the norm for pregnant bodies, looking perfect and symmetrical. However, many parents, particularly those who are not thin, will show their pregnancies in a variety of ways, and some feel more negative about that than others. Maddie, a small fat white woman, explains:

> I had some kind of unexpected body dysmorphia… Those kinds of feelings in early pregnancy when things started to change in my body, and especially as I started getting more of a belly. I'm already more of a curvy person, and I felt like I was just looking fatter and not pregnant.

For Maddie, she had expected to look pregnant similar to her friends or people she saw on social media who were much smaller than her. When her body did not meet these expectations, she says she felt like her body was betraying her:

> I had really bad morning sickness. I was just nauseous all the time. I didn't really want to eat, I didn't do anything, I was exhausted. As I became bigger in my belly, [I was] looking at pictures of other people who were pregnant and comparing the way that my belly looks compared to their belly and the way my body was changing versus their body changing. And then feeling like I wasn't being pregnant right. I wasn't looking pregnant the way they were looking pregnant.

Maddie was one of the more explicit regarding body image in relation to her pregnant body but these challenges appeared throughout the interviews. Participants felt that pregnant bodies, much like bodies generally, are supposed to look a certain way.

Teresa, an average size white woman, when asked if her body changed much during her pregnancy, explained her body did not change much due to her body type and size. However, she also associated her lack of change in her body shape because she was pregnant with a girl baby, stating that:

> The girl pregnancy body types are, you know, more internal, she wasn't a basketball. They say when it's a basketball pregnancy, those tend to more likely be boys, when it is just sticking out right in front and you don't see it from the back. When it more fits in your waist, like in your frame, that's more a girl pregnancy. So I definitely, in that sense, had that… more of a girl pregnancy body type.

Teresa acknowledged that her pregnancy looked "normal" since she was pregnant with her daughter. However, while she recognized her body fell into what she perceived as normal, she still described herself in ways that imply disappointment with her body shape before and during

pregnancy. She described herself as looking different compared to others and implied that "girl pregnancies" put more weight in the waist area which counters popular messages for women of having an hourglass figure.

While some self-described fat, chubby, and large parents felt dismay at not looking pregnant like others, some parents found comfort in accepting their body through the identification of being a parent, recognizing that they have never been thin and after going through pregnancy, becoming thin was less important to them. Teresa said "I'm not destined to be a skinny person, I never will be" and Jen, a fat white woman, "I never had that thing women go through about *now* not having a flat stomach, because I never had a flat stomach, and I never will, it's just never going to be flat." Fat mothers report feelings of disappointment at not having a "normal" pregnancy body but find they have less worry about achieving a thin body after pregnancy.

Conclusion

So far, I have examined how parents' bodies and embodiment shift in the transition to parenthood, messages of weight gain and the shape of their bodies. Before participants become parents, their expectations for their bodies change, whether they are gestational parents or not, and how they are treated by medical professionals and social services workers in the initial stages of becoming a parent is influenced by their starting weight. Thin and average size parents often see their transition to parenthood as an opportunity to forgo hegemonic standards of thinness because it seems that parenthood, in particular motherhood, trumps thinness as the penultimate expression of femininity. However, they also utilize healthist and moralizing language which reaffirms gaining weight is "bad" or undesirable. In other words, parents who are afforded the reprieve through their participation in parenthood recognize that this reprieve is

conditional on their status of pregnancy compared to others and know that the reprieve they felt during pregnancy is on a timeline. Fat parents are not generally afforded this reprieve in body weight and size expectation because they already did not previously conform to gendered expectations of thinness. Fat parents' bodies are medicalized, moralized, and stigmatized and are faced with additional barriers to expanding their family.

The way participants reflect on their transition into parenthood in conjunction with their embodiment is reminiscent of Cast (2004) and Ladge and Greenburg (2015) where the transition into and the adoption of the parenting identity brings together the social role and status of parent. My participants also show that transitioning into the role and status of parent is not only a social one, but physical. Prospective parents internalize and take on the social and physical expectations of parenthood, reflecting it back on themselves. Parents whose bodies are more normative are able to reflect back positive messages of embodiment, creating a social pathway and transition which is more optimistic than those with non-normative bodies.

Thin parents take on the physical expectation and acceptance of weight gain associated with the transition into parenthood and internalize the feeling that they can have relaxed beauty standards. However, while these parents want to have relaxed standards, they also recognize this is impossible as the beauty standards become apparent again once they have children. Fat parents are not afforded the opportunity of reprieve because they already did not fit into the hegemonic beauty standards associated with thinness. Thin and average-sized parents are rewarded with a reprieve, or at least the perception that they are entitled to this reprieve, such as Isabelle, because they had previously conformed to more normative expectations prior to the transition into parenthood. Fat parents are unable to reap the benefits of this supposed reprieve, even for a brief

period, and are instead further punished for their bodies through denial or gatekeeping of services needed to expand their family.

Parents also reflect on how weight is distributed on their body in addition to their actual weight. The physical changes associated with parenting impact social expectations of a gendered body, such as being thin or having full breasts for women and being muscular for men. Gordon (2023) identifies four different categories of fatness which can provide or inhibit certain privileges, such as being a "small fat" person compared to a "super fat" person. This kind of categorization can be helpful in recognizing how some bodies that are framed as non-normative, based on size and shape, can be accepted into the dominant group by adhering to specific rules and expectations. In this case, someone who considers themselves fat may not experience the same level of internal and external stigma as another fat person because their body *shape* still falls in line with hegemonic norms of beauty; such as women having an "hourglass" shape and less fat in their face and on their arms. In the case of gestational parents, the importance is that they are able to *look* pregnant regardless of their weight.

As individuals transition into the role and status of parent, normative pathways they internalize and understand are influenced by their physical body. Body size and shape will influence the ways in which parents are afforded adequate care, how they feel they can advocate for themselves, and their own internal feelings as a parent. As my participants show, the transition into parenthood is both social and physical. The liminal, or transitional, moment into parenthood gives insight into the way our bodies and embodied experiences are important moments which influence our social pathways and transitions into different life stages.

I now turn to how the transition to parenthood continues through the examples of pregnancy and birth. While I have included parents of all genders and took care to include non-

gestational parents, most of my participants were those who gestated and gave birth to their children. Because of this, the next chapter examines how the social construction and medicalization of birth further exemplifies the challenges of parenthood from a social and physical perspective. Through birth, and the ability to conceive and gestate children, parents construct their ability as parents through this important liminal moment where one *becomes* a parent through the act of the "appropriate" birth.

CHAPTER 5

BECOMING A PARENT

In this section, I primarily focus on gestational parents, those who carried their children and gave birth. I have chosen to focus this chapter to gestational parents, primarily, because cisgender mothers who gestated and birthed their children are the majority (34) of my participants. Further, my participants report that the actual process of *physically* becoming a parent through the process of birth is a particularly salient experience. While I primarily emphasize gestational mothers in this chapter, I also briefly mention adoptive parents as a comparative group to highlight how gestation and birth are constructed as the most socially acceptable way to build one's family, such as mentioning how biological relationships are desirable. I identify three themes regarding embodied transitions of becoming a parent: the construction of natural birth, natural birth as the most desirable and normative pathway to parenthood, and concerns of shame and guilt linked to bodily failure.

First, I examine the construction of natural birth. My participants offered diverse definitions of natural birth but overall demonstrate a consensus that natural birth is a vaginal birth, regardless of other medical interventions such as epidurals and inductions. However, natural birth is also viewed as a spectrum, where medical intervention *can* occur as long as their baby is born vaginally. Natural birth, as defined by my participants, is created on a spectrum to affirm their positions as "good mothers" if they were able to engage in "natural" birthing processes. This definition of natural birth highlights how C-sections are then, alternatively, constructed as undesirable, stigmatized, and failures (Bryant et al. 2007; Malacrida and Bolton 2012; Cripe 2018).

Second, through the construction of a spectrum of natural birth, parents express a desire for vaginal births. Many parents are unable to vaginally birth their children and/or actively choose scheduled births, either through inductions or C-sections (Malacrida and Bolton 2012; Cripe 2018) and parents struggling with infertility or in same-sex relationships have additional barriers to being able to conceive (Maroufizadeh et al. 2015; Pralat 2018; Laugher et al. 2019). Even when taking into consideration the choices parents have about their birthing experience, there is an understanding that C-sections are stigmatized and associated with a "medical" rather than a natural experience (Parry 2008). I find that parents' desires for a natural or "good" birthing experience puts them in conflict with medical professionals, with their own perceptions of their bodies, and simultaneously challenges and reaffirms embodied neoliberalism.

Finally, I end by discussing the embodied experience of parents who are unable to attain their perception of "natural" motherhood. My participants who identify as mothers or who are capable of becoming pregnant view their inability to engage in physical expectations of motherhood as embodied failure. As individuals transition into parenthood, there are expectations that they will go through specific physical changes, especially through birth and then breastfeeding their children. Being unable to achieve these goals can lead parents to question their ability to parent well if their bodies do not perform how they are expected to, again linking the social transition to parenthood with the physical. Parents must not only negotiate with the social expectations of parenting, such as nurturing and teaching children, but also the physical expectations of "sacrificing" one's body for their children, as a form of selfless motherhood (Malacrida and Boulton 2012; Fox and Neiterman 2015)

The promotion of natural births both contradicts and supports neoliberal ideology. Parents view natural birth as an empowering choice that challenges notions of efficiency and

transactional birthing experiences that they perceive in medical institutions. At the same time, parents can also reinforce individualism, self-reliance, and healthism. Although they emphasize health and individual choice, some acknowledge limitations to their choices. The preference for natural births, which I define as vaginal births with no to moderate medical intervention, may unintentionally reinforce ideas of biological essentialism and hegemonic femininity. Parents navigate a cultural shift away from dehumanizing neoliberal norms, rejecting certain aspects of neoliberalism while simultaneously reaffirming values like individual choice and the "right" decisions based on assumptions of health and biological imperatives. I now turn to an analysis of how natural birth is constructed on a spectrum, before examining the link of natural births to embodied desire and failure.

"No Interventions, No Medications": Constructing a Spectrum of Natural Birth

Parents put a lot of value on the way the births of their children take place (Bobel 2002). While the natural birth movement has been challenged by popular news media (Slee 2018; Grose 2019), a "natural" birth is often a goal for many parents (Bobel 2002). Natural births are generally defined as successfully having a vaginal birth with no to moderate medical intervention. The natural birth movement has been challenged through the framing that enforcing natural births reaffirms gendered expectations and misogyny and can unfairly pressure parents who have to have C-sections (Cripe 2018; Slee 2018; Grose 2019). As rates of C-sections continue to rise, especially in the United States (CDC 2022), parents have attempted to reject what they perceive as a medical model of childbirth and reclaim their agency through having more control and choice during birth, particularly through the construction of what they define as a natural birth. My parents define natural births in different ways, but with one notable exception, that natural births must include a vaginal birth. In this

way, the definition of a "natural" birth is contextual, as my participants construct their definition of "natural" on a spectrum in ways to reaffirm their comfort, sense of agency, and their abilities as a parent, in the birthing process.

There has been an increasingly prominent rejection of the medicalization of birth (Parry 2008; Morris 2020), primarily a rejection of perceived control and efficiency found in hospitals. To challenge cultures of efficiency and control in birth, parents often desire and aim to have what they describe as natural births. Parents construct natural births on a spectrum, meaning that identifying a clear and direct definition is challenging, where some define natural birth as far away from medical institutions as possible to simply not having a C-section. Participants who were able to have a vaginal birth constructed natural birth generally in line with their specific experience. For example, many mothers who gave birth in hospitals, needed their labor induced, or received pain medication during birth prided themselves in being able to complete a vaginal birth and this pride is linked to gendered expectations of motherhood (Malacrida and Boulton 2012). On the other end of the spectrum, some mothers took a more extreme approach to natural birth, where they gave birth in their homes, usually with midwife oversight, and no medications for pain relief (Parry 2008). Based on participants' experiences and definitions of a natural birth, I have found the best way to describe a natural birth as a vaginal birth with no to moderate medical intervention. While my participants had diverse explanations for what they considered to be a natural birth, one thing was clear, and that was a C-section was not part of a natural birth and was undesirable.

To examine the different definitions of a natural birth, I highlight two mothers who I see as exemplifying the two ends of the construction of a "natural" birth spectrum. First, I discuss Debra, a thin white woman, who had the strictest definition of natural birth. I also include,

alongside Debra, other mothers who are similarly aligned to her definition. I then introduce Scarlet, a white woman, who, through having a high-risk pregnancy, aligns her definition of a natural birth more with the outcomes of her birth rather than the process of her birthing experience.

Debra had one of her children at a birthing center and her second child at her home, both were under the advisory of a midwife. Debra was very clear that she did not want her children "born in a hospital and [sic] in a medical situation." Debra made her decision based on research she said she did prior to giving birth to her first child, she says:

> These choices I made [were] based on research showing the risks of hospital births, and I didn't want to be in a medical situation. I mean, I was willing to go if I absolutely needed it… I started off unconventionally, in that way, but it was based on research, it was based on solid science or, you know, the risk of C-sections, the risk of infection, risk of complication, the risks of a difficult birth… It just never felt right to me, I'm, like many people, very uncomfortable in a medical situation. So, I was trying my best not to make trauma happen along with birth, I wanted it to be beautiful and happy.

Debra's construction of a natural birth is also associated with her attempt to avoid a traumatic birth and the risks that she believes are more associated with hospitals, such as increased risks of infections and feeling a lack of control over her birthing experience. Additionally, giving birth outside of a hospital increased the odds, to her, that she would have a more positive birthing experience.

For Debra, and others, a natural birth is moving away from medical intervention and medicalized birth. Medicalization is defined by Conrad (2007) as "a process by which

nonmedical problems become defined and treated as medical problems" (4). While the study of medicalization has most often been associated with illnesses and disorders (Conrad 2007), childbirth has also been increasingly medicalized, where there are heightened risks associated with the pregnant body regardless of if there are any issues present (Lane 1995; McPhail and Mazur 2019). For example, Lane (1995) describes how a medical model of the body, especially the pregnant body, is framed as being inherently risky, where doctors may increase medical surveillance to prevent potential risks. Lane (1995) and others are not suggesting that there are no risks in childbirth, but rather that the pregnant body is seen as inherently risky which can lead to increased control and surveillance even when no illness or ailments are present. These presumed risks mean that expectant mothers are often more surveilled by doctors throughout their pregnancies, as medicalization is a type of social control (Conrad 2007). Lane (1995) finds that the risk framework for pregnancy implies that the body is always ready to fail and that increased medical surveillance potentially ignores:

> the iatrogenic risk of medical interventions… social control over women by the use of risk vocabulary to describe maternity… and when risk has monopolized the debates about childbirth to the exclusion of… emotional satisfaction and control over the events and procedures surrounding birth (99)

Debra, then, challenges the medicalization of birth by choosing not to have children in a hospital. While the medicalization of childbirth is informed by potential risk, Debra views medical institutions as creating heightened risk through potentially unnecessary interventions, iatrogenic risk (negative outcomes associated with medical intervention), and taking away her ability to have control over her birthing experience.

Others construct natural birth as simply a vaginal birth, even if they gave birth in a

hospital, but did not receive medical intervention. For example, Meg, a thin, biracial Asian and white woman, who had three hospital births, had a midwife instead of a medical doctor and was clear that her definition of a natural birth was one that included "no interventions, no medications, the epidurals… no relief." However, most parents consider vaginal birth with medical intervention as a natural birth, where clear lines are usually drawn between vaginal births and C-sections.

C-sections have generally been stigmatized among mothers (Cripe 2018; Tomsis et al. 2021). The participants who had given birth were overwhelmingly against C-sections. Many viewed C-sections as unnatural and not a "real" birth or an "easy way out." Research has shown that women who are able to have vaginal births see it as a selfless sacrifice of motherhood and is something that mothers should want to do for their children to reduce potential risk during birth (Bryant et al. 2007; Malacrida and Boulton 2012). This is not particularly surprising. C-section stigma is also contextual, where those who receive unexpected C-sections feel more stigma toward their body for not performing as expected and those who plan their C-sections are seen as selfish, irresponsible, and engaging in more risky birth. C-sections are generally regarded as undesirable and stigmatized, rendering women who do have them to feel like failures because their bodies did not perform a normative function (Moore and De Costa 2003; Cripe 2018). The process of *giving* birth implies notions of agency and autonomy amongst participants, marking them as adequate mothers through what their *bodies* could do for them.

Meg, similar to Debra, was also adamant about natural births having no medical intervention. Meg described opting for "natural" relaxation methods like showers and massage to overcome labor pain:

> But I wanted as little my modification as possible, I wanted to be left alone as much as possible... The only real interventions that they provided were to be like, 'Oh, you're in pain? Would you like to use the shower, or let's make you be upright, so gravity can aid you.' That kind of thing. They also did like that as vaginal massage… so really gentle things like that.

Additionally, Debra described that her body knew what it needed to do and she had faith that her body would perform naturally.

> And I never, never, for a moment wanted any kind of medication. It was just, like, didn't want anything. I didn't need anything, my body was doing what it needed to do and was fine.

Part of the spectrum of a natural birth is the understanding that bodies are built to perform certain functions because of biology and that messing with this natural process can be detrimental to the health of the parent or baby. Morris (2020) explains that inductions and epidurals during labor can put pressure on the birth parent and baby, causing increased or decreased heart rates which can alarm medical providers into performing emergency C-sections. By opting for less medical interventions, participants like Debra are able to, in their view, reduce potential risk associated with hospital births and also ensure that they can maintain control and agency throughout the birthing process.

While some participants described natural birth as being as far away from medical interventions as possible, others framed their understanding of natural birth as generally being able to have a vaginal birth and having a healthy baby. I highlight Scarlet, a fat white woman, to show how a natural birth can also be understood within medical spaces.

Scarlet framed her birth experience in the outcome of the birth rather than the process,

unlike Debra and Meg above. Scarlet constructs "natural" birthing processes in relation to norms of having a generally healthy baby and does not place her own body at the center of constructions of "natural." Instead, Scarlet welcomed medical interventions to ensure the health and wellbeing of her child. Scarlet has dwarfism and is considered "obese", classifying her pregnancy as high risk, which prompted doctors to provide additional care at larger hospitals since she lives in a small town with fewer medical resources. While birth is considered highly medicalized in the U.S., with most births happening in hospitals and constructed as "risky" for the body, Scarlet experienced additional surveillance because of her dwarfism and body size. On one hand, while Scarlet's dwarfism prompted additional concern because of the potential for more "risk," she found a benefit in the additional surveillance because she was able to see more ultrasound images than other mothers, which made her happy, saying, "I got a bunch of extra ultrasounds… which I enjoyed getting… I got to see my baby more!" Also, she does not report feeling abnormal when interacting with her doctors, and felt generally supported throughout her pregnancy.

However, at 37 weeks pregnant, after she had been cleared to give birth at her local hospital, after another ultrasound she was told her baby had enlarged bowels which could have been a blockage. She says:

> Okay, I made it 20 weeks I'm halfway, 24 weeks the baby is considered viable. And then, you know, I was almost 37 weeks when that happened [when it was found her baby had dilation of bowels]. I was almost ready to give birth and all of a sudden there's like this, something could be wrong with me. And I'm like, 'wait, what?' especially after having multiple ultrasounds. Like why didn't I know about this before? Like, how did they not see this prior?

She described being frustrated considering the amount of surveillance she had been under and wonders how the doctors never caught it previously which had altered her perspective of having a "natural" birth. Her construction of a natural birth was dependent on having "nothing wrong" with her baby and being able to give birth locally, in a hospital, and not having to travel. After traveling for an additional ultrasound, she was ultimately able to give birth locally without the need for a C-section. For Scarlet, she was able to have a natural birth even when considering the amount of technological intervention she experienced.

While Scarlet constructed birth as natural based on the general health of the baby, her birthing experience is also intensely medicalized as someone who needed additional surveillance, though she appreciated, rather than felt ashamed, of this surveillance, saying she "had a smooth pregnancy" and "feels okay" about the process. On one hand, Scarlet perceived a generally positive experience because she was able to receive the care and gain access to the resources she may have needed. While her pregnancy went smoothly and she did not need explicit interventions, such as a C-section, it is noteworthy that she identified the doctors as creating a potentially risky situation by not catching the issue of enlarged bowels in her child, rather than locating it in her overall pregnancy experience. This may also be positive, where Scarlet does not view herself as inherently problematic, instead recognizing her body as being smaller in stature than others due to her dwarfism but does not find any concern related to her *own* body throughout her pregnancy; instead locating any issues of abnormality with medical institutions and doctors.

Contrary to the literature and other participants, Scarlet finds the value in having additional surveillance through medical intervention (such as ultrasounds) because these interventions provide her with the opportunity to participate in a natural birthing process,

namely a vaginal birth. The technology allows her to act autonomously and independently (avoiding explicit interventions during the birth) and it is when the doctors make a mistake (such as, in her view, not noticing a problem until she was 37 weeks pregnant), that her autonomy and desired independence was put at risk. Participants constructed appropriate birthing processes in a society that tends to have stark lines drawn for what is considered a "natural" birthing experience. In the case of Scarlet, she defined a positive pregnancy and birth experience in relation to her child's health, that her possibility of a natural birth was tarnished when it was made possible that her baby may have health issues in utero and blamed doctors for not seeing it sooner considering how many ultrasounds she received. However, the very fact that she needed monthly ultrasounds compared to average of two ultrasounds during a 40-week pregnancy, additional resources and travel already marked her pregnancy as "unnatural" when compared to others' definitions of a "natural" pregnancy and birthing experience. Similarly, Turner (2002) questions the use of "natural" to describe most births in the U.S., even her own "natural" birth. Even through midwives, birthing processes are marked by modern technology. Birthing processes defined as natural can be the "masculine pull" of technology, where women can attempt to take control and be subjective beings in the process (Tomsis et al. 2021; Turner 2002). However, it is through technology that expectant parents can be assured their children are healthy and okay.

Scarlet has a unique approach to her embodiment during pregnancy as she did not locate any abnormality in herself. To her, the enhanced medical care is what made it more normal, allowing her to have a natural birth, albeit in a hospital. In a medicalized world, where pregnancy and childbirth are incredibly medicalized, all of these interventions or potential for intervention can become "natural." For Scarlet, the problem is not the medical interventions,

but when these interventions fail; the doctors and institutions failed at potentially intervening fast enough which was a threat to her idealized birth. Again, the baby ended up being fine but the anxiety she felt at potentially needing to travel again to give birth was placed squarely on the medical institutions and doctors, not on herself or her body.

Meg and Debra have strict views of natural birthing processes, attempting to resist a medicalized version of birth. They constructed a natural birth as also normative, that this *should* be the way to have children because there are ways to deal with discomfort of birth that do not involve what they consider to be unnatural processes, such as medication. To them, this is also the least risky kind of birth. Both also resist the neoliberal pull of hospitals, where they are concerned with detachment and efficiency-based procedures. However, they also reaffirm healthism, highlighting that a natural birth is the healthiest, and therefore right, decision but are quick to assert that it is ultimately an individual choice. On the other hand, Scarlet constructed notions of natural and normal in relation to the health of her baby. While Debra mentioned the increased risk of a hospital birth, especially in relation to medical intervention, Scarlet negotiates risk differently because of the amount of surveillance she already had to endure through her pregnancy because of her size, both her weight and dwarfism. The surveillance and technical interventions actually gave Scarlet comfort knowing her baby was healthy. It was not until the technology failed that she felt her natural birth plan was at risk. Scarlet affirms technological intervention and relies on it to ensure the health of her baby. Scarlet constructed a natural birth within the confines of medicalized birth processes that is informed by her body being a site of risk. However, Scarlet rejects notions of individual responsibility, a characteristic of neoliberal ideology, when she refused to blame herself and body for technological failures.

While my participants frame natural birth on a spectrum, natural birth, however my participants define it, is desirable. Namely, participants desire a natural birth and the ability to produce biologically related children because of the value placed on cis-heteronormative family dynamics in the U.S.

"It Was Not the Labor that I Wanted": Natural Birth as Desirable

A natural birth, generally defined as a vaginal birth by participants, is most desirable usually because of the association of possible risk with a C-section or because of the stigma associated with C-sections and feeling like their bodies are defective (Topcu 2019; Roth and Henley 2012). Morris (2020) outlines the possible risks of C-sections, such as infections and longer times to recovery. Other researchers have attempted to de-stigmatize C-sections to try and reaffirm women's choice and empowerment if they must get a C-section (Cripe 2018; Moore and De Costa 2003). Being able to have a choice regarding a birthing plan is also desirable, especially when considering values of choice, agency, and autonomy, especially among mothers. Additionally, the importance of a natural birth is also rooted in expectations of biological relationships between parents and children (Pralat 2018). Parents who are unable to conceive and gestate a pregnancy, have been found to go through alternative routes or desire possibilities that place them closer to heteronormative family structures (Pralat 2018). In this section, I examine how my participants understand their position and viewpoints in relation to natural births, particularly how natural births pertain to instances of agency, empowerment, and coercion.

Because of power differences between medical professionals and parents, there is often conflict when parents have a specific birth plan that doctors may not follow. Rosa described her experience during her second birth when she decided to have a doula present. She says this

experience was completely different than her first because the doula took the time to explain the changes her body was making and what to expect during labor. There is the emphasis on understanding one's body and trusting it to perform as needed, similar to Debra, discussed above, who said "my body was doing what is needed to do." Rosa described the doula as her advocate, someone who helped her to feel empowered in her decisions regarding the birth of her second child. She says her doula informed her of her rights as a patient and helped her feel "overall more knowledgeable about the process, which made a huge difference." She continues, saying:

> It's funny because I have gone through it, but like, not really, because in my first delivery, it was like, my body was physically there. But you know, like, I kind of just follow the direction of the doctors and the nurses and like what they were telling me to do. I was quick to take the drugs when they numb you [epidural], I wasn't really active in my labor and delivery, it feels I wasn't prepared at all.

Rosa has a less strict definition of natural than other parents and opted to give birth in a hospital for both of her children. She defined her experience of a natural birth as one where she is not immediately given pain relieving medication and is given autonomy and agency in making her decision regarding birth.

Parents who are more aligned with natural birthing processes often perceive doctors as trying to be efficient, making it easier for male doctors in particular to "get in and get out." Parents who find natural birth more desirable often do so because of the chance to have autonomy and agency over their birthing experiences and can challenge notions of efficiency that they perceive doctors to be adopting in their practice. While many parents explained that

birthing plans rarely happen as expected, they ultimately want to feel in control of their decisions. Stacey, a fat Black woman, discussed how she had wanted a natural birth and, like similar parents, wanted to let her body do what it was meant to do. However, Stacey says she felt pressured by doctors to be induced early with her first child because of her size and the risk that her baby would be too big to birth vaginally if she were allowed to go into labor naturally.

> I let the doctors talk me into being induced with [my son]. And now looking back, I should not have done that… All of a sudden, I went into distress and so did [my son]. So we're in there laboring one minute and then the next they're like, 'we really need to take him out.' So I had the C-section. And then it was several hours before like, I even got to hold him or anything. I was on such heavy medication that I barely remember what was going on, honestly.

In this instance, Stacey had wanted a natural birth, one characterized by allowing her body to "do what it was meant to do." However, because of pressures from doctors, Stacey relented to being induced. Stacey's experience with her doctors is reminiscent of the work by Lane (1995) who discusses the medical model of childbirth, where *more* risk is created through the pregnant body regardless if any ailments are present. Stacey was told that her son had the potential of being born too large because of her weight. However, after she was induced, and then had to undergo an emergency C-section, her son was born a month early and at only 6 pounds. Stacey's main concern with the induction was that she viewed it as the reason she had to have a C-section. According to Morris (2020), inductions can have negative effects on the baby and parent, leading to increased risk of unplanned C-sections. Also, her son was of average size, nowhere near being born too large for her to attempt a vaginal birth. If her body

had been allowed to carry to term, she may have avoided unnecessary surgery. In this instance, the worry about the health of her baby, highlighted by those in authority, coerced Stacey into making choices she otherwise would not have made which had an iatrogenic result; the medical intervention of mislabeling her son as too large, needing to be induced, resulting in the need for an emergency C-section.

Stacey goes on to describe the birth of her daughter, her second child, where she had to change doctors and described the way she was treated, “To me, [the new doctor] just didn't seem like she cared about me or my baby. It was just get me out to the next person.” Stacey had to see multiple doctors while pregnant with her second child, and while she did try to advocate for herself, she says she felt mostly bullied by her doctors, especially when she tried to challenge the increased surveillance that they put her under:

> I would go in for regular ultrasounds. And there came a point where I said ‘I don't want all these ultrasounds. I don't need all these ultrasounds. This is ridiculous.’ And they didn't like and so the doctor came in and she just started telling me how if I do not continue to come in for these appointments, my child could die, I could die all these awful things could happen. She came back in with two other doctors with her so three doctors standing over me as I'm sitting in this chair telling me how if I don't do what they say, I'm putting me and my child at risk of who knows what like it could just end terribly. I felt like I was being bullied.

Stacey tried to reject the overmedicalization of her pregnancy by drawing a boundary in how many ultrasounds she was receiving. However, Stacey expressed feeling bullied when multiple doctors accused her of putting her and her child at risk by rejecting medical interventions.

Stacey goes on to say that there was nothing that came up health-wise to support the need for all her ultrasounds and appointments. Stacey evoked her health status, that there were no health reasons to warrant the additional visits besides her weight, to challenge the over-surveillance of her pregnant body.

While Stacey attempted to allow her body to go into labor naturally for the birth of her daughter, she was once again told she needed to go to the hospital to be induced after an ultrasound revealed her child was not moving as much as they should when in utero. Stacy says:

> At one of the appointments, [the doctor] said, 'Okay, you know, your baby's not moving as much as we want your baby to be moving. You need to go to hospital right now to be induced'. Well, you know, I need another a reason because I just heard [my child's] heartbeat. You just saw her move. She's, she's just fine in there.

However, Stacey ultimately decided to still go to the hospital even though she tried to challenge the doctor's advice.

> We did end up going [to the hospital] that evening, so I could be induced, but I felt like, by the time I went in, I was having regular contractions, it felt like my body was on its own going into labor. And I actually asked [the doctor] about that. And they said, 'no, no, that's not what's happening.' So I don't know, you know, they gave me the drugs, they put me in labor. It was an awful experience. It was definitely not the labor that I wanted, at all. And by the time we'd been there for, like, two days again, I think I was just like, 'You know what, I give up, just take the baby, I'm tired of this.'

I clarified with Stacey after this story what it was like for her to try and have a vaginal birth after C-section (VBAC), she says “Oh, yeah, that was a whole ‘nother thing. I was like, ‘No, I'm trying for vaginal birth this time, like, I didn't get the first time.’ I definitely had to fight to be able to do that.” Stacey’s desire for a vaginal birth, and also a natural labor process, is informed by her desire to have agency and control over her birthing decisions and reject the medical model of childbirth. She is clear that with her first child, her son, she was not even allowed to carry to term. For her daughter, Stacey tries to reclaim her agency and be empowered in her birthing choices. Rather than feeling empowered, even if she had to give birth in ways she did not want to, she was instead made to feel bullied and coerced, a feeling other fat mothers in my study reported and has been documented in other studies (Miller and Baker 2022).

While there is a spectrum in the ways that parents construct natural birthing processes, ranging from vaginal birth with little to no medical intervention, being able to go into labor naturally (without being induced), to having a vaginal birth with medical interventions, most parents desired a natural, or at least a vaginal, birth experience. Parents negotiate messages of increased risk associated with C-sections and being induced while also listening to the advice of medical professionals. Parents reported a desire for a natural birth as also a desire to have agency and autonomy during the birth of their children, and to perform in expected gendered ways. In this way, parents can challenge medical institutions that they view as trying to take away their agency, ignoring their embodied knowledge in favor of medical or expert knowledge (Malacrida and Boulton 2012; Béhague 2002). However, parents who cannot, or choose not to, engage in natural birthing experiences are often left with feelings of shame and guilt. By asserting their right to an agentic and possibly empowering birthing experience and

challenging a medical status quo specifically through the ability to have a natural birth, there is inadvertent messages sent that frame other parents as potential failures if they are unable to have a "perfect" or desired labor.

"My Body Failed Me Again": Embodied Shame and Guilt in Becoming a Parent

Parenting, especially motherhood, is most often associated with biological processes, primarily the ability to gestate, birth a child, and be biologically related to their children. This is not unreasonable considering this is a statistically normative way that folks become parents, and considering the social importance placed on gestational mothers and the biological processes associated with bodies sexed as female. My participants, mostly cisgender women, root much of their identity in being mothers and express value in this. My participants expressed shame and guilt if they are unable to perform normative biological functions, including having to receive medical interventions during birth and the ability to breastfeed their children. Linking these feelings back to transitions and pathways, my results show that bodies that do not perform as expected (such as being able to have a vaginal birth and breastfeed) means there are disruptions in the normative pathways to parenting. Physical limitations become internalized, and we see the linking of the social and physical during this transitional moment. Bodies, then, are able to disrupt parenting expectations, creating a non-normative pathway in a normative transition, which can lead to further internalization of guilt and shame.

Katy recalled the birth of her son, describing it as traumatic. Katy had a negative experience with her birth, where her epidural was placed wrong in her back so she was unable to receive pain relief medication during contractions. After attempting to birth her son vaginally for 5 hours, she was told her son was "sunny side up" meaning he was facing

upward and had gotten stuck in her birth canal. She was moved into an emergency C-section and because her epidural had been placed wrong, she was unable to receive pain medication through it. She recalls going in and out of consciousness as doctors informed her that her baby was stuck even in the C-section. Afterward, while her and her baby both survived, she was told that there had been a low chance of survival given how long her baby was stuck and how long she remained "open" during surgery. She tells me, "I view myself as like a feminist. And it was just very hard for me to wrap my mind around why I felt like my body was made to produce this child and I couldn't even do that right." In this instance, Katy consciously recognized and honored feminist discourse that challenges biological essentialism of women but still found herself feeling negative when she could not perform what she perceived to be a natural, biological function.

We may have biological processes but our responses to these processes are influenced by the society we live in and interactions with others. For example, gender is a structure that permeates institutions and interactions and bodies are constructed through sexist, racist, classist, and ableist norms. If you get pregnant or are a person who is (assumed to be) capable of getting pregnant, then your "natural" bodily function is additionally used in a way to deny opportunities because of gender essentialism associated with motherhood. The opposite is also a reality, where those who do not adhere to these normative expectations of supposed motherhood are also stigmatized because they are not adhering to norms of a sexed female body. Therefore, the natural argument can be used in multiple ways to stigmatize specifically those who can get pregnant. You are either at risk because you *can* get pregnant or are stigmatized because you can get pregnant but opt not to, or "fail" to (in the case of women who may feel like failures or like they are "broken" because they hypothetically *should* be able

to get pregnant but are unable to for a variety of reasons or have complicated pathways to parenthood).

Katy's feelings also conflicted with her identification as a feminist. She attempted to challenge the norms and assumptions of cisgender women being inherently capable and wanting to give birth, and recognized that female bodies are unfairly held to a standard most associated with reproduction but also felt immense guilt and shame that her body "failed" at a natural gendered and sexed process. Additionally, because of her son's traumatic birth, his head was slightly malformed because the plates in his head shifted during birth. Because of this, the plates in his mouth were also misaligned making it difficult for Katy to breastfeed. After going through a lactation specialist, Katy ultimately decided to just bottle feed her son with formula and donated breast milk, saying:

> My body failed me again, on not being able to breastfeed, like I must just not be cut out for this or what's wrong with me? I wouldn't have survived if I was in the field picking strawberries back in the day, and they just birth kids in fields, like I would have died like, you know, it's just a weird, like, I never thought that would be my thought process. But it's like, I felt like my body was failing me.

The ability to breastfeed is important for many mothers and the significance placed on breastfeeding is usually associated with natural processes of the body. My participants often discussed the choice to breastfeed as one of the first decisions they had to make and also experienced judgement regarding their choice. Taylor, a white woman, when asked about judgement relating to her being a mother, responded first explaining that choosing to breastfeed or not was usually a first question, and judgment, by doctors, saying "whether or not you're going to breastfeed whether or not they're going to vaccinate whether or not you're

going to standard like even the cloth diapering got like weird looks and all these other things." Martucci and Barnhill (2021) find discourses around "natural" and breastfeeding shift but maintains positive connotations, such as breastfeeding as easy, inherent, innate, no/low technology or synthetics, pure and less risky, and ultimately healthier. However, complications arise when bodies are unable to perform tasks that have been constructed as "easy," especially with something as imperative as feeding our children. When breastfeeding is constructed as the "healthiest" way to feed your child, parents are confronted with more feelings of guilt and shame if they are unable or choose not to breastfeed their child (Kukla 2006; Scagell 2017; Martucci and Barnhill 2021).

Katy expressed sadness that her body did not perform how it was supposed to, did not perform "naturally" as she had been led to believe. At one point, she blamed her body, stating that her son was a big baby and she just had "narrow hips." What is important to recognize is the construction of a "natural" birthing experience considered the norm and expectation, even when 1 in 3 births are through cesarean section (CDC). Normality has been constructed over time and can de-stigmatize or additionally control individuals and groups of people (Foucault 1990). As Katy was unable to adhere to normative expectations of birthing, she expressed feeling a general failing in her body and as a mother.

Some women in my study who had C-sections did not feel external pressures related to their C-sections, but instead felt internal sanctions of shame and guilt rooted in assumed societal beliefs. The shame experienced by some of the women who had C-sections did not have to explicitly come from others but just from the general understanding of how society constructs an appropriate birth. While the CDC reports that one in three live births are from C-sections, women experienced guilt and shame that they were not able to vaginally birth their

children. Multiple women discussed the concept of a "push prize" where there is a sort of constructed competition between women if they are able to "push out" their baby.

Ann, a fat white woman, who had C-sections for both her children, says:

> I have some hang ups… or I think that vaginal births are just a better way to go… weird hang ups about being *strong enough* to give birth, which I am right? [but] If they're beautiful, wonderful children, I am done feeling bad. But yeah, I had some serious hang ups so that you know, I [also] intended to do it without medication.

Ann recognized her "hang ups" about C-sections and associated them with her ability and strength to give birth. As parents negotiate messages about appropriate birthing processes, expectations of one's ability to birth also becomes expectations of their supposed capabilities as a parent and person, such as being "strong enough" or seen as weak. While Ann highlighted that she is done feeling bad about her C-sections, she also described the expectations she originally had, such as also not taking medications.

Parents' desires for vaginal births are also influenced by subsequent births. Once someone has a C-section, it is generally understood that all subsequent births will also be via C-section. AVBAC is possible, but not usually recommended by doctors because of possible risks and a history of malpractice lawsuits in the 1970s and 1980s, although more recently these risks have been put into question (Habak and Kole 2024). Laura recalls when her doctor, during her second pregnancy, had concerns that Laura wanted to try for a vaginal birth after previously having a C-section. Laura reiterated that once someone has a C-section it is understood and expected that all births after that will also be through C-section. Laura was experiencing immense anxiety over the birth of her second child and while she was determined

to have a vaginal birth, her doctor recognized how much her anxiety was getting to her over the small possibility that her previous C-section area could rupture. She really wanted to try for a vaginal birth after being disappointed that her first live birth was via C-section, she recalled her doctor telling her “first off, like, there's no prize, like, you don't get a different baby. If you do a C-section over a vaginal birth, like one birth is not supreme, or better than any other type of birth.” Laura’s doctor recognized her anxiety and attempted to support her decision while also making it clear that birth is not a competition. Ultimately, Laura decided to have a C-section with her second child and forgo the potential risks associated with VBAC, even if those risks are generally minimal (Habak and Kole 2024).

Parents, particularly mothers, know there are societal expectations to have a vaginal birth because of the link to natural biological functions and gendered expectations of motherhood. Additionally, parents of all genders value “natural” births because of the societal importance placed on biological relationships, which is particularly salient for parents who are unable to conceive for a variety of reasons.

Cleo, a fat, non-binary fat parent, who adopted their two children after 8-10 years of trying other avenues of fertility treatments, says “And like, you know, my big disappointment is that, like, I never got to say, well, I get a push prize for having a baby. That's really what it is, it's really around the material base of like, I didn't get a present for having a baby.” Cleo is referencing that they did not really get to participate in the rituals of “having” a baby, such as a baby shower and receiving presents for themself and their babies. While Cleo never intended to have a vaginal birth even if they got pregnant, they recognized the social importance of carrying and eventually having a baby. That there are specific rituals and milestones associated with the physical, and supposedly natural, expectations of childbirth.

Cleo, who was not able to conceive "naturally," however, tried to conceive as naturally as possible by getting donated sperm and going through IUI treatment with the intention of becoming pregnant. After about a decade of trying to conceive via IUI, they no longer wanted to deal with the physical and emotional turmoil of trying to conceive and found the time and financial burden to be too much. Cleo eventually recognized that attempting to conceive as close to "natural" as possible was also rooted in the desire to have a child that was biologically related to them. However, they decided it was not worth it because the child would not be related to their partner anyway and so they re-evaluated why they considered a biological relationship to be so important in their pursuit to expand their family. However, Cleo valued a biological, therefore natural, relation in their understanding of normative parenting (Pralat 2018; Jennings et al 2014; Golderbg, Kinkler, Hines 2011). If their body was "built" to do this, then why not, since this is the way one is "supposed" to have children if they have the body that "can".

Cleo exemplifies the way normative pathways to parenting can become non-normative via the body and embodiment. While Cleo was unable to conceive with their partner, they still tried to engage in a *more* normative pathway to parenting by at least trying to become pregnant so that their child would be biologically related to one parent. It was only after they were unable to conceive for almost a decade through various failed IUIs, that they began to shift their values in the construction of family; if their child would not be related to their partner anyway, why did it matter so much for the child to be related to Cleo? The liminal space of *becoming* a parent is where these different embodied trajectories can be highlighted.

Other parents describe being exceptionally proud that they did not undergo C-sections. Meg and Alicia both discuss the importance of having their child vaginally but also construct

the idea of natural childbirth differently. Meg was adamant about her choice to birth her child naturally, where natural is defined as vaginal with no medical intervention. Meg says her choice was informed by stories from her grandmother who was not awake during the birth of her children and had no recollection of the event. Meg highlights the importance of the embodied connection with the birthing experience. Alicia, a small fat, white woman, on the other hand, was also determined to have her children vaginally but had to be induced for both pregnancies. Alicia says she had her babies naturally and did not want to undergo a C-section even though both pregnancies had different complications, her first related to high-blood pressure and her second child was born at 42 weeks rather than 40, her body just never "naturally" went into labor. In this case, both Meg and Alicia have different conceptualizations of natural birth but agree that vaginal births are natural in comparison to C-sections.

When considering the construction of a normalized pathway to parenthood, it is important to note what is constructed as the appropriate pathway to parenthood is different based on the individual. Particularly, there is also a hierarchy related to what is a normative and non-normative. A normalized parenting trajectory is most often associated with biological relation, a gestational relation, and usually a vaginal birth. However, others construct normal to mean that nothing is inherently "wrong" with their baby or with the birth (regardless of how the birth occurs). Some participants do not construct a normative pathway based on the birthing process but rather if everything goes according to plan during the birthing process. For example, Scarlet, from above, only questioned the medical processes of her pregnancy after she became aware that something may be wrong with her child during an ultrasound at 37 weeks pregnant. However, Scarlet only marked this potential outcome as non-normative because up until then, all of the medical intervention she had received had been normative in

her transition to parenthood. Medical intervention, control, and surveillance *was* the normative pathway for her even though her pregnancy was considered non-normative do to her label as "high risk". But for Scarlet, her body and the medical interventions were not cause for concern, because the medical intervention would, eventually, produce a healthy baby through a normative birthing process. This construction of normality was only challenged once she viewed the medical professionals to have failed in their job of ensuring everything was okay with her baby. Scarlet's pregnancy, while considered high risk and therefore potentially non-normative, could still on to the value of a *more* normative birth experience because of being able to successfully have a vaginal birth and have a healthy baby. However, parents who engage in non-traditional pathways to parenting have different relationships to the construction of a natural birth.

Parents who had children in non-conventional ways (usually queer parents) also try to abide by normative pathways as much as possible. For example, queer parents may opt to try and have biological children because of an assumed biological imperative to have children or feel an importance for having biological relation and wanting to be viewed as a "normal" family (Pralat 2018). Parents who can participate in these avenues of childbirth, however, also usually have the capital to do so, where they meet both financial and weight restrictions in order to participate, such as being able to afford IVF, finding a doctor willing to perform the procedure, and not exceeding the weight limits for the IVF clinic, such as Cleo.

My participants who adopted their children, and do not currently have biological children, also express either trying or wanting to try other avenues to become parents. Similar to Pralat's (2018) findings relating to gay, lesbian, and bisexual parents, there are still values placed on having biological children though access to procedure like IVF or surrogacy are

extremely costly. The ability to have biological children is a privilege that those with biological constraints cannot participate in. Additionally, the desire to participate in having biological children reaffirms the value in genetic relationships regarding family dynamics. Daniel, for example, when I asked how he feels he is treated as a parent, describes frustrations with his family when he expresses fatigue from parenting responsibilities, he says:

> The first word that pops into my head is just "shitty." When you're fostering and adopting, and we have these kiddos in our home… we're just trying to do everything we can to maintain some semblance of normalcy for that kid, and it can be exhausting… You put your heart and soul into this, try to build [the child] back up… and people who aren't in your shoes say "oh, well, you're just so tired, you should just give them back, you should just give notice, you don't seem like you're enjoying this," and like, they would never say that to someone who had their kids.

Daniel expresses frustration that his family would suggest he just "give [his son] back" because he feels no one would say that to someone who physically gave birth to their children. Throughout the interview he expresses the difference in how he was treated compared to those who have biological children, feeling that his relationship to his children is not as important or strong and that he can easily "give them back" to the state. There is also consideration that these responses to Daniel could be because he is an adoptive father rather than an adoptive mother, showing gendered differences in parenting expectations as none of the adoptive mothers in my study reported explicit or implicit messaging to "give back" their children. However, Daniel also shared a past desire for surrogacy, saying he wanted to have biological children but ultimately did not have the finances to support this desire. Daniel simultaneously

recognizes the importance of challenging hegemonic ideals of family, namely the suggestion that genetic relation is stronger, and also desires to have biological children but is limited due to financial constraints.

Conclusion

How one constructs the appropriate or most socially acceptable way to become a parent is usually also associated with construction of what is considered natural, but we have also moved very far from supposed natural processes to today's norms such as a hospital birth. Even though a hospital birth is not the most "natural" way to have children, it is the statistically normal way in the U.S. However, there are also variations here, where those who have hospital births define a hierarchy in relation to natural when they talk about "push prizes" for having a vaginal over cesarean birth, if they use pain medication during the process, etc. There is a deep pride and value held if someone becomes a parent in the supposedly "right" ways which also lends them the opportunity to achieve a specific kind of social status, namely being seen as a good parent, especially a good, and selfless mother.

Constructions of natural births both challenge and support neoliberal ideology and embodied neoliberalism. Parents discuss natural births as being empowering, allowing them agency, and challenges notions of efficiency and transactional birthing experiences. However, parents who ascribe more value to natural births also do so through highlighting values of health and individual choice, though some parents say they recognize limits to choose, such as needing to have an emergency C-section. Mothers, through embodied neoliberalism, can challenge the neoliberalization of medicine (such as efficiency and commodification of birth) and simultaneously support notions of individual responsibility and self-reliance through their ability to not rely on others during the births of their children. The overall value of natural

birth over other avenues and valuing vaginal births with no medication over other vaginal births can inadvertently reaffirm notions of biological essentialism and hegemonic femininity. Parents do not tend to lump these into competing messages and are instead renegotiating a neoliberal culture which often dehumanizes us. Through the rejection of certain neoliberal notions (such as efficiency) parents also reaffirm these values in how they speak about the importance of individual choice and themselves making the "right" decisions based on assumptions of health and biological imperatives.

Because there is an assumed ability to "choose," parents who are unable to adhere to normative expectations of childbirth must then contend with potential shame and stigma, resulting in internalized guilt for being unable to "produce" how they are supposed to. These feelings of guilt and shame, particularly from mothers who are unable to adhere to constructions of a natural birth, reveal the social norms of parenting as being rooted in ideologies of neoliberalism, healthism, and cis-heteronormativity.

In constructing the "ideal" parent as one who has a female body (and is therefore thought to be a woman) and how a female body which reproduces is thought to be "natural" and that naturalness is constructed, generally, through the ideas of normative pathways to parenting and how closely one can achieve "natural" bodily functions. For example, in the case of C-section versus vaginal birth, the person who has a C-section upholds a semblance of a normative pathway to parenting in that they were able to gestate their child and conceive naturally, through assumed cis-heterosexual sex, or at the least carry their child, such in the case of Cleo.

As parenting bodies are constructed as inherently female, and therefore inherently a natural process because of the expectations of the female body as the ability to conceive,

gestate, and produce children through a vaginal birth, expectations parenting bodies are rooted in an embodied neoliberalism perspective that female bodies are supposed to produce in specific ways and not need individual interventions. Individuals who are unable to adhere to these standards experience internalized stigma and recognize the ways they have violated norms of parenting. If they are unable to engage in compensatory behaviors, parents with non-normative bodies must negotiate often implicit and explicit messages about their bodies as inherently wrong and therefore also unnatural.

I center bodies in relation to parenting in a way that attempts to challenge biological essentialism and the hegemony of biological processes as most "natural" which also constructs them as most "normal," where the ways bodies perform can create non-normative trajectories in a socially normative pathway. The normalization and naturalization processes of the parenting bodies *both* challenge and reaffirm neoliberal notions of individual choice and health. Parents can challenge medical institutions which seek to efficiently move parents through their birthing process but then inadvertently support social norms which lead to internalized shame and guilt when parents cannot or do not adhere to normative parenting processes.

CHAPTER 6

BODY AFTER BABY

So far, I have discussed how parents perceive and understand their bodies and embodiment before and during the transition into parenthood. In this chapter, I examine the ways that parents perceive of their bodies at the time of interview. At the time of the interviews, my participants had children aged three weeks to 30 years old, some even having grandchildren. Parents provided a range of perceptions about their bodies and how their transition into parenthood has impacted their current embodiment. Parents experience external and internal challenges as they navigate the world in different sized bodies and they negotiate meanings attached to assumptions about their size, health, and their status as parents. Participants respond to normative meanings about their bodies by challenging or acquiescing to normative body expectations and distancing themselves from others who have non-normative bodies.

I find that parents change their perspectives over time. Their size, the longer they are a parent, aging, and general changes in social norms contribute to participants' changing attitudes about their bodies. As participants engage with the process of aging, they are more likely to begin questioning aesthetic standards of thinness and focus more on what their body can do physically and adopt a more neutral perception about their bodies. In other words, parents try to challenge normative body weight and size through constructing a framework which attempts to reduce the aesthetic social value of their bodies, instead focusing on what their bodies can physically do despite external messages of health and fitness. Fat parents also have a unique viewpoint about their bodies after becoming a parent because their bodies, to them, did not change much throughout parenting, as they did not necessarily gain weight. Instead, fat parents

discuss aging and the actual act of parenting as impacting their embodiment more so than their weight.

I find two salient themes related to body and embodiment after becoming a parent. First, parents have varying embodied responses to how their bodies have physically changed after becoming a parent. Fat parents report certain expectations of physical changes relating to their role as a parent and that these expectations and messages are more likely to come from others. Second, I find that parents shift their perceptions of their bodies over time, especially in relationship to their children. Parents with younger children report feeling more insecure about their bodies than parents with older children. They are also cognizant of the social messaging regarding the post-natal body, particularly no longer *looking* like a parent, especially a mother.

"I am Strong and Capable": Physical Changes and Expectations of the Body after Baby

Parents reported physical changes in relation to the act of parenting and aging. These physical changes influence parents to re-evaluate the relationship to their body by shifting from ideologies of an aesthetic social capital to thinking more about what their bodies have done and continue to do. These changes also make some parents more conscious of how they talk about their bodies in front of their children. As they change the way they talk about their own bodies, they also change how they feel about their body.

Ann, a fat white mother, describes trying to change how she talks about her body to try and undo the feelings of insecurity that she adopted from her mother. She says:

> My mom had pretty serious body image issues when I was growing up and I was aware of all the ways that she looked at her body, judged her body, and then judged my body… [saying] 'wear that because it will hide your chubby arms' or whatever. I didn't want my kids to carry that shit. I had really tried to talk about

> my body in a positive way in front of [my kids]. I did it for them, more focused on what my body does that what it looks like.
>
> I knew that I didn't want to pass along my own body image issues. My children will laugh about it, but I tell them that I am beautiful, and I am strong and capable. The messages they get about how I feel about my own body has changed how I feel about my body.

Through evoking more positive messaging in front of her children, including that she is strong and capable, Ann has changed her own relationship to her body by recognizing the things her body is capable of, such as later describing her love of hiking and swimming. Additionally, Ann's identity as a parent and her role as a parent has changed how she views her body. Ann, through becoming a parent, recognized the ways negative body talk, especially from one's parent, can negatively impact a child. Previous research (Sole-Smith 2023) has also explored instances of "fat talk" by parents to their children, where fatness is described or alluded to as something that is bad and to be hidden away, similar to Ann's mother making comments about Ann's "chubby arms." Ann's experience as a fat and active parent has empowered her to find value in her body through physical activity and her role as a parent. By feeling pressure to *not* pass on body image insecurities to her children, she has also changed her own perspective relating to her body, particularly because she often repeats how capable her body is in front of her children. In other words, Ann represents fat parents who are able to reframe their perspective of their bodies through their identification with parenthood by being positive role models for their children.

Some participants, however, use the instrumentality of their bodies to separate or distance themselves from others. For example, fat parents may highlight the ways they are healthy,

engage in physical activity, or have not had to receive medical interventions in order to frame themselves as a "good fatty" (Gibson 2022). Daniel, a fat white man, for example, recognized the institutional discrimination he faces as a gay, fat, father and the negative messages he receives from his family, but also positions himself as "one of the good ones" when talking about his physical activity and eating habits.

> My family consistently reminds me of my weight [as] the issue. My sister likes to go out and play soccer with her son… And my mother and sister will be like, 'well, you should go out and play soccer with your kid.' And I'm like, 'I don't like soccer. I don't like running and playing soccer. I've never played soccer before I don't even know how to kick a ball,' like, my husband, he's more than capable to go run around in the field and play soccer with our kid, who doesn't want to play soccer by the way. But, you know, because I'm fat, I should probably get out there and do some exercise with him. Because what if he wants to do cross country running and I'm not being supportive? Because I'm not running with them? And I'm like, okay, so where were you [his mom] when any of us did sports, were you running and doing training with us? How many parents do I see out there on the football field during practice or running in doing sprints with their kids? Like, I can be supportive without you being thin.

Daniel described the pressure he receives from his family about being more active with his child and attributes these messages and pressure to him being a fat father. Daniel reported that his husband, who is thin, is never pressured to play games like soccer with their son and says he is also frustrated because his son does not have interest in soccer anyway. Daniel feels his identity as a supportive, and therefore good, parent is challenged if he is not actively participating in

sports/physical play with his son. In this case, the instrumentality of his body is used as a way to determine his ability to be a good parent. Daniel does reject this notion initially, questioning the capacity for him to be a supportive parent whether he is "training" or "running" with his son or sitting on the sidelines because most parents do not actively train with their children.

However, Daniel shifted when trying to defend that he *does* exercise and physically play with his son. His annoyance toward his family is that since they see him as fat, then he must not actually be serious about exercising or playing with his son. Daniel, to me, said that he does in fact take his son outside to play regularly in an attempt to show that he does do what his family wants, but they just do not see him do it. What is particularly noteworthy, however, is that he also evoked the stereotypical image of a fat person. He says:

> It's really obnoxious how they like to put in that 'Oh, well, you should go on walks more with your son. You should go outside more with your son.' I'm like, 'we have a front yard and he [husband] has a job,' but like, we go out on the daily. Just because I'm fat doesn't mean I don't go outside. I don't sit inside in my chair for 48 hours at a time. I don't I don't know what [my family] wants.

Daniel initially questioned the need for him to be thin and physically active to be a supportive father. Daniel clearly understands the double-standards he experiences as a fat father, being pressured to be more physically active than his thin husband, while also distancing himself from other fat parents who potentially do *not* play with their children and instead "sit inside" all day. In this instance, Daniel does not find as much joy in movement and physical activity as others do. Instead, he sees physical activity as something he is pressured into doing by his family, which he openly challenges when he is with them, but is also sure to explain that he is not like "other parents" who do not physically play with their children. While Daniel may verbally

challenge physical expectations of parenthood to his family, he was still clear to tell me how he personally does in fact physically play with his son, presumably, unlike other fat parents.

Cleo, a fat, white, non-binary parent, described similar irritations as Daniel, explicitly recalling instances they felt particularly judged because they are not as physical with their children when it comes to playing sports. I asked Cleo how they felt their body has been judged after becoming a parent:

> Yeah, I feel [judged] in terms of like, sportiness. I feel like there's an assumption that like, you know, my kid runs track, I should probably be out running his workouts with him. But I can't run, like I used to run in high school, but my knees are fucked up from running in high school and from dancing as a teenager, like, I can't run. Like literally, when I was in my 20s, the doctor was like, if you keep running, you're gonna need new knees in your 40s. And I was like, but you're not gonna give it to me because I'll be fat. So you know, better stop running. So like, I feel like there's judgment around that.

Interestingly, Cleo, just like Daniel, provided the imagery of a parent participating in sports drills with their children. In comparison to Daniel, who simply stated he does not like to run, Cleo explains that they do not run for specific physical limitations caused from running and dancing as a teenager. While Cleo acknowledges there was a time when they could have possibly ran with their child, they also recognized the expectation that parents should be more involved in their children's sports. Cleo continues:

> I feel like, *and again, I don't know if it's true*. But, I feel like if I'm not chasing after my kids at the playground, the assumption is that I'm too fat to chase after my kids. Not that I just don't want to chase after my kids. I would not be chasing

> after my kids if I was thin. But like, I feel like the assumption is that I'm not doing it because I'm fat. I feel like when I'm at the playground and like other moms are standing and I decide to sit, the assumption is that I'm deciding to sit because I'm fat. It's not because I've been up since 4:45 [in the morning] and I'm tired.

Cleo is one of the more vocal parents about anti-fat stigma but struggles to explicitly identify where they hear these messages or if these messages are "true." As above, Cleo says they are not sure if "it's true" that their weight is judged by others but that at least perceive their weight to be judged if they choose to sit when doing certain activities. Cleo has internalized social messaging about anti-fat bias which prompts their perceptions that others are judging them for being fat, regardless if others are or not. Cleo described other instances of this:

> I feel like there's judgment around [sitting]. I volunteer for bathroom duty at my kids' school, which is a travesty. But, my choices are stand in the hallway or sit on a folding chair and I sit on the chair because like, I don't want to stand for two and a half hours and yell at small children, I can yell at them just as well if I'm sitting.

As Cleo continued to describe their experience with a teacher, they begin to stammer, previously extremely confident in how they were speaking to me, trying to relay the interaction:

> So like, you know, it's… I feel like, you know, when teachers see me like, they're like, 'Oh, you're sitting down, huh?' And I'm like, 'Yep, I sure am'. Because I'm not being paid to be there, they'll thank me when the kids come back to class with washed hands.

While Cleo seemed uncertain before, they began to make similar connections to Daniel, that their activities and choices as parents would not be an issue if they inhabited thinner bodies. Thinner bodies are able to present the idealized instrumentality, where a thin body at rest has the ability to, supposedly, be used in physical ways unlike a fat body. Those living in a fat body are reminded that they are perceived as lazy or incapable because of their fatness. Cleo continues:

> I always feel like as a fat body, that if you were doing something that a thin body would be doing, [others] assume that you're doing it because you're fat and lazy, not because you want to. I feel like there's always, and again, *this could just be my shit*. But you know, living in a fat body for 1000 years?
>
> *I don't think it is*.
>
> I feel like there is weight associated with fat bodies, or judgments of weight associated with fat bodies that don't exist for other people. It's like, I'm just thinking of an added… Like, if you're sitting on the bench on your phone and a thin mother's sitting on a bench on their phone. And like, both might be judged as like, you're not paying attention to your kids. But then there's this, I'm additionally judged because I'm sitting as a fat person. I'd be judged for sitting as a fat person, wherever I was, *because* I'm a fat person. I should always be optimizing my ability to lose weight by engaging in cardiac activity, cardio activity of some sort. It feels like 'how dare you not be jogging in place?'

Cleo was initially uncertain about what they were experiencing in various interactions with parents and teachers, questioning if their experiences were an example of anti-fat bias or if they are putting too much stock into these interactions. They also evoke the theorization of liminal fat offered by Kyrölä and Harjunen (2017), where individuals are expected to always be in fear of

becoming fat, and if they are fat, are expected to always be trying to lose weight, such as how Cleo they must always be "optimizing" losing weight. As they continued explaining these interactions, Cleo became more confident in asserting that their perceptions of anti-fat bias are coming from somewhere rather than being explicitly internal. They come to the conclusion that living in a fat body means they have actually experienced messages of double standards their whole life. Unlike Daniel and Ann, two fat parents who recognized issues of anti-fat stigma but still, whether consciously or not, reaffirmed notions of ability and instrumentality, Cleo more explicitly challenged messages that they need to always be physically active and that their physical abilities should not matter.

Parents, in different ways, shifted their relationship to their body after becoming a parent. Fat parents in particular reported different perceptions of physical judgements from others compared to thin parents, which influenced how they internalized their views on their own and others' bodies. Some parents seek to undo the damages about their bodies that they adopted from their parents as children, find value in more physical strength, and find different expectations for different body sizes and shapes. Parents can challenge and acquiesce to external messaging about their bodies after becoming parents, finding ways to show they are capable and fit parents through being able to physically play with and hold their children and also questioning the double-standard fat parents experience. Parents also report a shift in changing body perspectives after becoming a parent, primarily through their new identification with the role and status of parent and how this may impact their children.

"My Body Did This Wonderful, Beautiful Thing": Changes in Body Perspectives

While participants reported both positive and negative feelings about their bodies in relation to parenting, others took more neutral approaches to try and reduce their general

anxieties and feelings of responsibility about their body size. Gailey (2014) has previously found that fat or "overweight" individuals tend to focus more on their mental attributes rather than physical ones as a way to overcompensate for their bodies. My participants, on the other hand, were more likely, regardless of size, to focus on what their bodies achieved and what their bodies could do physically, rather than focusing on mental capacities. Participants see themselves as still being able to find joy in their bodies and challenge aesthetic expectations. By finding value in what their bodies can do despite their size, participants are able to reclaim agency about their bodies and attempt to undo harmful messages they have received about their bodies. How they manage messages about their bodies, however, changes with their different pathways to parenthood.

Parents manage internal feelings about their bodies and embodiment after having children. Gestational parents often emphasize the importance of being able to physically carry and birth their children whereas others found that becoming a parent has allowed them to distance themselves from beauty expectations. In Chapter Four, I discussed how thin and average size parents, particularly mothers, felt they were able to experience a reprieve from weight stigma when they were transitioning into the role of parent, usually through pregnancy, because of their previous ability to embody hegemonic norms of femininity. Fat parents, on the other hand, explained that they often felt they were not afforded the opportunity to gain or even maintain their weight because their fat bodies were stigmatized by medical professionals and their families. In this case, fat parents, even while pregnant, were expected to maintain or even lose weight during their pregnancy or lose weight to conceive. Thin parents, while being able to enjoy the possibility of weight gain, recognized that this reprieve would not last forever. The timeline for when perceptions of external messaging regarding reprieve from weight and size

stigma is fragile and dependent on the previous size and shape of the person prior to becoming a parent. However, as parents grow older with their children, many begin to question the necessity of caring about how their body looks and generally trying to adopt body neutral or body positive perspectives.

Parents also expanded on how parenting has changed their body in relation to physical strength. Parents', and everyone's, bodies change over time due to age and the kinds of activities we engage in. However, changing parents' bodies are usually associated primarily with pregnancy and motherhood. This is not unfounded considering that *most* parents are mothers who have given birth to their children. Through the pregnancy process, muscles extend, limbs become swollen, and stretched skin is expected and common. However, parents' bodies represent so much more change than just that of pregnancy, especially in relation to physical strength *after* becoming a parent, regardless if one was a gestational parent.

While Ann, above, relayed the ways in which she expresses being able to do physical activities, Ronni, a thin Latino father and one of the few men in my study, and Alicia, a small fat white mother, commend the changes their bodies have gone through because of the need to carry their children. Ronni and Alicia both expressed insecurities with how their bodies look but expressed positive relationships to their newfound upper body strength from carrying their children. Alicia said, after I asked her to describe herself physically now, "I definitely have more arm muscles. I feel like there is a term called 'mommy muscles,' I just have to help carry these kids everywhere!" she laughed before continuing, "The multiple bags, diaper bags, and also my stuff and everything, strollers, pack 'n' plays… ya know, a friend that hasn't had kids and now can't hold as much as I can." While Alicia later lamented her current body size, stating that she does worry about being "in shape" but also feeling guilty about going to the gym, she

still finds ways to acknowledge the growth her body has gone through physically. The value of the physical strength of her body, being able to pick up her children as well as all of their belongings means that she is physically stronger than someone who does not have to engage in these activities.

Ronni also associated his upper body strength with being a parent, but while Alicia attributes it to what she calls "mommy muscles," Ronni explains that it is his role as a father. Ronni says:

> As the dad, you carry the kid a lot, and they get really heavy. Like, your arms, just like, if you're not strong enough, your arms are gonna be super tired and sore. And so, like, that's a thing too, you have to have that upper body strength to just stand and hold like a 10 pound weight for an hour.

Ronni, similar to Alicia, explicitly related his physical role as a parent to holding his child. However, there is also a gendered aspect, where both Ronni and Alicia refer to their gendered parenting roles, as a mother or father, to explain the need to have and develop muscles. Both Alicia and Ronni attribute upper body strength and a change that occurs with being a parent and recognize the importance of being able to carry their children. It is interesting to note how they both also attribute this to their gender, where mothers begin developing more muscles compared to other women and how Ronni sees it as his role as a father to be strong to hold his children, because "as the dad, you carry your children a lot."

Alicia and Ronni explicitly discussed the importance of physical strength and being able to engage in physical activities as parents, whereas Ann focused more on how she talks about her body to her children. Each participant presents social and physical expectations of parents: Ann as the one to send messages to her children about bodies and Alicia and Ronni highlighting the

expectations of both mothers and fathers in the physical care of their children. However, this could also be because Alicia and Ronni, at the time of their interviews, had much younger children, whereas Ann's children were older teenagers. The different relationships to their bodies can also be contributed to their age and the age of their children, where Ann felt her children were more likely to internalize how she spoke about her own body and possibly turn it on themselves.

Participants also highlight their ability to have children as a reason to find value in their bodies outside of how their body looks. Abby says that she "definitely doesn't want to be bigger" but also "happy… because a lot of women can't have babies, so I am grateful that nobody had to give me a child." Abby reports positive feelings toward the instrumental nature of her body, because she was able to conceive and have her children compared to others who cannot. Abby emphasized the importance of biological family and the physical ability to become pregnant. This is noteworthy because of the importance Abby placed on the function of her body over the aesthetic of her body even through reinforcing normative pathways to parenthood.

Maddie, who earlier described feelings of body dysmorphia during her pregnancy says she is still "working with a lot of feelings of insecurity" about not liking the way she looks, but says she is "getting to a place where I am just kind of neutral about my body… it's the body, it does what it needs to do." Maddie, while not expressing an overtly positive relationship with her body like Abby, expressed at least shifting toward more of a body neutrality perspective. Body neutrality is most often associated as a response to body positivity, where those who adopt a body neutral approach challenge cultural expectations of body negativity (usually seen through idealized thinness) and body positivity (feeling as if one has to always love their body)

(Leboeuf 2019; Pellizzer and Wade 2023). Some participants rejected messages of body positivity because they felt body positivity was still too focused on bodies and does not provide space to have "bad" body days. Isla described a shift from body positivity specifically to engaging in a more body neutral approach as she has recovered from disordered eating habits. Isla says:

> That was a huge shift for me, because I thought I had to love [my body] and thought that was the goal of recovery. And I realized it's not, it's about… I actually don't want to spend that much time thinking about my body. I don't want to spend that much time contemplating my belly or my arms. So that was huge for me, it was this "ah-hah" moment, 'is this something I really want to think that much about?' Positivity is still focusing on the value of the body, right? Your value is your body even though now it includes being fat, but it's still valuing your body over other stuff.

Isla described contemporary body positivity as still being focused on the body but instead of spending a lot of time hating your body, you are now expected to always love it. Isla initially struggled with her weight after giving birth to her daughter. Isla tells a story about shopping, "[I would say] 'I just had a baby' as a way to almost, excuse my body… I remember shopping for a coat and telling the cashier 'Oh, I just had a baby,' but my daughter was two at that point, but it was because I was in a bigger size." Later in the interview, she said, "There's sort of a forgiveness right after you had a baby. You're not expected to work out or have your stuff together. But I remember trying to figure out, how can I start working out again… The excuse is no longer valid, [my daughter is] one now." Isla found the consistent focus on body as still

valuing aesthetics and worrying about what your body looks like. Isla prefers to now focus on activities that make her feel good rather than look good:

> I do powerlifting now, which I love, because it's the body, but focuses on strength, not the appearance. I used to work out to sculpt my arms or chisel my abs, and I never had chiseled abs (laughs). Now, I want to be strong and powerful. It's more about… So, I walk a lot more, I used to run, and running is great, but there's these moments where you feel like you want to die and it's painful, it's uncomfortable. But walking always feels good… I focus more on what it *feels* like.

Participants were very aware of the cultural messaging that women needed to "get their body back" after pregnancy while also reporting that they felt they had a bit more leeway in gaining weight specifically because they were now a parent. Laura recalled reading magazines about fit parenting and finding the message that she should be working out to "remain tight" for the sake of her husband. Parents were conscious of the way their bodies were "supposed" to look after becoming a parent. Thin parents, such as Laura, recognized social messaging that gaining weight during pregnancy was acceptable as long as she lost the weight later. However, she said she never felt the need to lose weight quickly after she gave birth, saying:

> I wasn't one of those people who, ya know, went to yoga to lose weight or 'keep it tight.' I went to pregnant yoga though, because it felt good to stretch and just hang out with other pregnant people. But it wasn't like I needed to keep it tight, none of that. I don't think I even thought about weight with either of [my children] until after I had [my second]. I was gonna be a bridesmaid and thought 'alright, gotcha.'

Laura, a thin Latina, explained, through her education on gender issues, that she never worried about getting her body back, especially for her husband. However, when different social pressures presented themselves, she recognized the importance of having to look a certain way, such as for a wedding. While she challenged patriarchal ideals of "looking good" for her husband, she understood the importance of social messaging related to losing weight for a wedding, even if it was not her own.

Katy highlighted that, in the few months after her son was born, her weight gain did not bother her. Weight gain, in the case of pregnancy, is a normative transitional expectation of motherhood, at least for thin parents as discussed in Chapter Four. However, it was the fact that she did not lose any of the weight in the months after the birth that was difficult. Katy's experience aligns with previous research suggesting the liminality of women's bodies and weight after birth, that weight gain is understood through cultural norms, where there is a constant threat of becoming fat (Fox and Neiterman 2015; Kyrölä and Harjunen 2017). Kyrölä and Harjunen's (2017) conceptualization of liminal fat highlights the importance in recognizing how fatness is a constant threat, especially to women, as well as the liminal and transitional nature of bodies overall. Bodies are expected to change, especially through biological changes such as aging and parenthood (Umberson et al. 2011; Fox and Neiterman 2015; Brown et al. 2017). While these changes are expected, there is also social expectations and messaging which reinforces these changes must be fixed. The liminality, the transition, is only appropriate for a short amount of time and is indicated through external and internal processes, expected to be controlled by the individual (Kyrölä and Harjunen 2017).

Katy primarily focused on internal feelings brought about by her own discomfort with her weight after the birth of her son. While her internal feelings were negative, she expressed

receiving positive affirmations about her body, especially from her husband. Talking about her husband, she said "[he says] I looked the most beautiful I've ever looked [and] 'if you've never lost half a pound in your life, this would be totally fine with me."' Katy said she appreciated his support but that she "couldn't see that" for herself. For Katy, it was not only the weight gain but the signs of weight gain and pregnancy, like stretch marks, and the scar from her C-section. Weight gain appears to be okay at the time of pregnancy, but the signs of weight gain and pregnancy become less accepted the longer time progresses after becoming a parent. As Abby alluded to with her comments about the "mom bod," Katy appears to have issues with *looking* like a mother. Additionally, Katy sees her pregnancy and parenting pathway as non-normative, due to her emergency C-section, the challenges she had with feeding her son, and the amount of weight she gained. The non-normative pathway of her transition into parenthood has influenced her current embodiment, where the signs of her pregnancy and the birth of her son linger. While her husband attempted to give positive and supportive messaging to Katy, which she appreciated, her own internal insecurities about her body outweighed his attempts to make her feel more comfortable in her body.

While many parents described feelings of insecurity about their bodies before and after becoming parents, others have tried to challenge the ever-present cloud of constant body transformation. Participants have attempted to find value in their physicality, and while some struggle to transition away from worrying about aesthetics, others have spent more time focusing on joys they find in movement and spending time in their bodies and with their children.

Conclusion

Parents' embodiment shifts with changes in social norms, societal pressure, and aging. These changes can prompt a reevaluation of how they view their body in relation to parenting.

Fat participants, having been fat for most of their lives, tend to focus more on what their bodies can *do* and shift away from focusing on the aesthetic capital of bodies. Fat parents, in my study, through their experiences of being fat for most of their lives, tend to have a more positive relationship to their bodies precisely *because* they do not feel the pressure to become thin again. In other words, while fat parents reported experiencing discrimination and stigma due to their weight in the process of becoming of a parent, fat parents reevaluate and challenge social norms of thinness because, while they may be prompted to *lose* weight, they do not know what it is like to be thin and therefore begin to challenge social expectations of thinness and societal double-standards about weight. Differences emerge between thin and fat participants, where thin parents, or who were thinner prior to becoming a parent, embody more pressure to lose weight after becoming a parent or are less likely to challenge the desire to lose weight.

Parents' age and the age of their children also impact how they discuss and perceive their bodies. Parents with older children are more aware of how they talk about their bodies in front of their children and worry about continuing cycles of body shame. Additionally, as parents age, they become less concerned with how their bodies are perceived by others. Parenting and aging intersect as social pathways which can challenge hegemonic standards of thinness and beauty.

Over time, parents tend to shift their perspective regarding their bodies and embodiment. It appears that the longer they experience parenthood, the more they question conventional ideas of body aesthetics, particularly thinness. Parents with older children describe challenging normative body ideals, such as rejecting aesthetics in favor of body neutrality and exploring movement because it feels good to their body. Parents with younger children appear more likely to have more negative internalized feelings about their body, questioning when they *should* be losing weight and generally struggling to accept their body.

CHAPTER 7

DISCUSSION

Life course scholars have examined the ways social transitions can have varying degrees of normative and non-normative pathways depending on social location and the body, including age, race, gender, class, and health status (Abel 2007, 2008; Elder Jr. and George 2016; Brown et al. 2017; Mollborn, Lawrence, and Kruegar 2021). There has also been some work considering the ways body weight and size can negatively impact access to social and financial capital, through barriers to employment, promotion, education, and marriage, especially for fat women (Puhl and Brownell 2001; Crosnoe 2007; Reece 2019). Sociology of the body scholars, however, have not fully utilized a life course perspective. I have sought to bridge the gap between these two theoretical orientations to conceptualize the process of *liminal embodiment.* In this chapter, I further explain how liminal embodiment was developed through the study's results and describe limitations and future directions before my final conclusion.

I first review the previous chapters to reorient my findings with my initial research question. I then move into a discussion of *liminal embodiment* and how this is a useful theoretical lens for understanding the ways the physical body is also social, impacting how we engage in social transitions in non-normative or normative ways. Particularly, I argue that parenthood is a moment of *liminal embodiment* and is an excellent starting point in considering embodied transitions. The shift to identifying as a parent has important implications for the social and physical changes that bodies go through and then the outcomes of various social pathways. I also provide a discussion of my study's limitations and potential future directions, concluding with my final call to consider the importance of the physical body in social research.

I began Chapter Four with a consideration of how parents recalled their experiences prior to becoming a parent. By focusing on the events leading up to my participants transitioning into the status and role of parent through birth or adoption and how they felt about their changing bodies during this time, I parsed out how parents' body weight, size, and shape impact their transition into parenthood. Body weight, size, and shape are important factors in how the social and physical transition into parenthood is constructed as normative or non-normative. Thin and average sized parents reported feeling that pregnancy allowed them a reprieve from beauty and weight standards, where their participation in pregnancy specifically gave them leeway to challenge a culture of thinness. Fat parents, on the other hand, were not afforded this opportunity, experiencing additional barriers to receiving the resources needed to expand their family. While parenthood is considered a normative transition in the life course, the body weight and size of prospective parents can frame their transition as non-normative.

In Chapter Five, I focused on gestational, cisgender mothers, recognizing the majority of my participants, cisgender women who gave birth to their children. I examined how the *process* of birth is highly contentious among parents, especially mothers. Through the construction of "natural birth," and the challenge to adequately define what natural birth means, hierarchies are created between women who are able to perform what they define as a natural birth. Women who choose not or are unable to have a vaginal birth, report embodied notions of failure to act independently and be self-reliant. Women who can achieve what they perceive to be a natural birth, see themselves as challenging neoliberal and medicalized birthing practices which they believe shapes birth into a process of greater efficiency and commodification. However, the nuance in how gestational mothers construct their perceptions of embodied "choice." Participants see birth as the clear transition into parenthood, especially motherhood. While challenging

neoliberalism and increase in medicalization of childbirth, mothers also reaffirm embodied neoliberalism. Mothers whose bodies can perform "natural" functions, such as vaginal birth without intervention or assistance and are able to breastfeed, are exalted as mothers who are healthy, independent, and selfless.

Finally, in Shapter Six, I asked parents to discuss their current relationship with their bodies and embodiment and if they felt their perceptions of their bodies was linked to being a parent. Participants who were younger or have younger children often described their bodies through nostalgia or seeking to change their bodies now. These participants reflected on how their bodies looked before they had children and often lamented the fact that they had not lost the "baby weight" and expressed guilt toward going to the gym, and therefore not spending time with their children, and shame regarding their current body size and shape. Parents who were older or had older children often found more joy in their bodies and expressed changes in how they talk about their bodies to their children. Parents with older children, such as teenagers, were more likely to consider how negative self-talk may influence their children's self-esteem and so altered their "body talk" to focus more on what their bodies can and could do. Interestingly, fat parents, or those who self-described as overweight or plus-size, were more likely, regardless of their age or the age of their children, to have more positive relationships to their bodies. Fat parents, especially those who were fat prior to becoming a parent, had never experienced what it was like to live in a thinner, more normalized body, and found their priorities shifting after becoming a parent. Fat parents, in the initial transition to parenthood, were not afforded the reprieve thin parents experienced, as discussed in Chapter Four, but were more likely to develop positive relationships to their body seemingly *because* they felt they would never be able to conform to expectations of thinness.

In this project, I had one major question in mind: how does the role and status of becoming a parent impact parents' embodiment? I have examined the process of becoming a parent, from conception and early adoption processes to giving birth and adopting children and then to their current perception of their bodies after having time to adjust in their role as parent. My goal in this project has been to offer a theoretical lens which merges life course perspectives with the study of body and embodiment. Through what I have called *liminal embodiment,* I argue that bodies are always in transition and our embodied experiences and ideologies are important moments which influence our social pathways. Liminal embodiment is a useful framework for analyzing connections between physical and social transitions, offering insight into how we may seek to control and change our bodies before, during, and after important life events, such as new employment, marriage, aging, and, of course, parenthood. Parents and the transition into parenthood offer a unique lens to analyze liminal embodiment, as this transitional stage is highly valued and critiqued in society. The transition to parenthood is also a clear example of the way physical and social changes intersect, where the social transition into the role of parent is also connected through physical changes, like pregnancy, using assisted reproductive technologies, and the increased importance in perceived health status.

The way parents understand their relationship to their body before, during, and after becoming a parent is complex. Kyrölä and Harjunen (2017) use the concept of *liminal fat* to explain the way we interpret messaging of fatness and weight gain and how we believe the fat body to be understood and experienced. Through the conceptualization of liminal fat, fat is a constant threat. The liminal nature of fatness then, is the risk that we may become fat or that we are always working toward no longer being fat. While I agree that socially dominant messages are mostly about avoiding becoming fat and many of my participants do have negative feelings

about their weight, there are important implications for how body weight and size are contextual. Rather than constructing weight gain as always a threat, body weight and size stigma is associated with the social context of the potential weight gain. *Liminal embodiment* offers an alternative framing of weight-based stigma, where our embodied experiences and ideologies are important life stages within our social transitions and pathways, rendering weight gain, in this case, as more or less severe in relation to external judgements and discrimination. Messages spread in media, education, and medicine construct weight gain as a risk, but there is more to be understood from circumstance when weight variations, even weight gain, may be *personally* experienced and constructed as a positive change or even expected through different social pathways and transitions, such as pregnancy.

The liminality and transitional nature of the body is not limited to how the body looks but also how the body is able to perform in expected ways. Much research has been done to analyze the transitional, or liminal, space of parenthood as it relates to rites of passage into adulthood, particularly womanhood and motherhood, and a particular moment in which someone is no longer a child (Choi et al. 2005; Malacrida and Boulton 2012). My research adds to previous scholarly work in my examination of embodied transitions in addition to the role and status transitions of parenthood. Pregnancy offers an opportunity for parents to "let go" of diet culture expectations or feel they can become "fat and happy," but only if the parent had previously lived in a thinner body. Parents who are unable to vaginally give birth to their children, breastfeed, struggle with infertility, and adopt, wrestle with messages that frame them as inferior parents. Recognition of the different outcomes in the transition into parenthood provides an understanding of how individuals can experience a relaxation of body ideals for brief periods of

time, create varying degrees of hierarchies within social transitions, and how transitions can be perceived as normative or non-normative based on the physical body.

There are contentions within fat liberation contexts which complicate just how mutable the body actually is, such as how easy/difficult is it for someone to gain/lose weight, how much is related to genetics or the environment, and the challenges of asserting it is one or the other. These contentions are generally rooted in challenges to neoliberal and heatlhist ideologies which construct the fat body as inherently unproductive and in need of state interventions. In addition, any ill-health is seen as self-inflicted through the assumptions that fatness is a choice and simple diet and exercise would alleviate any ailments. Fat liberation and fat activist groups challenge these assumptions generally through asserting that weight gain is not a choice and that there are biological implications for some people to be fatter than others (Gordon 2023). LeBesco (2011) has argued that a biological root to fatness is also problematic. By reducing fatness to simply a biological understanding, LeBesco (2011) raises concerns about eugenicist rhetoric, where the search of a "fat gene" can lead to the attempted eradication of it. It is through an understanding of liminal embodiment that there can be attempts to bring together these contentions, that physical transitions are also social, and that body weight has important implications in how social pathways are experienced as normative or non-normative.

Regardless of our individual ability to lose or gain weight, bodies change throughout the life course, especially as we age or go through transitional phases, such as becoming a parent. Individuals gain and lose weight overtime, and receive messages about idealized, appropriate, and functional (parenting) bodies. It is through a recognition that bodies will change shape and size and that body shape and size does not automatically mean good or ill health, that we can

begin shifting practices to better support individuals through major life transitions, regardless of their body weight and size.

Limitations

This project sought to unpack the nuanced and complex relationship between social transitions and embodiment, and it is not without limitations. First, fathers are under-represented in this study. While I did my due diligence in attempting to recruit fathers, even asking participants who were married to men if they would be willing to pass on my information, purposefully reaching out to men I knew personally, and reaching out to the admins of Facebook groups dedicated to fathers, I only have three fathers in my study. Previous research has found that men who have pregnant partners go through similar physiological changes, including changes in hormones and weight gain. Additionally, while it was not discussed at length, the popular discourse around the "Dad Bod" would provide an important analysis of how soft, masculine bodies can also be attractive compared to more traditional, hyper-masculine representations of men in the media because of the association with fatherhood. A comparison of perceptions of the "Dad Bod" and a "Mom Bod" would further highlight the gendered and racialized expectations of parenting, the body, and perceived health status.

Second, there is a limited number of parents who engaged in non-normative pathways to parenthood, such as using assisted reproductive technologies and adoption processes. While this makes sense considering cisgender women are statistically the most likely to have given birth and are the primary caregiver of their children, having more parents who had non-normative pathways to parenthood would strengthen the analysis of how transitions into new life phases are both physical and social. Recent research has examined how queer parents utilize assisted reproductive technologies to frame themselves as more "normal" by engaging as closely as they

can with “natural” birth and establishing biological relationships with their children, such as lesbian couples using IVF or gay men using their sperm for a surrogate (Pralat 2018). In the context of my study, these pathways would not be considered “natural” because of the medical interventions but would provide these families with some social capital by still being able to claim biological relationships to their children, which is an important component regarding the connection of the social and physical.

Third, my methodology of retrospective interviewing has limitations as well. While retrospective interviewing has been shown to be more accurate than previously thought, even as more time passes (Casey et al. 1991; Must et al. 1993; Parry et al. 1999), there are limitations to interview methods, including different positionalities, social location, and social desirability bias. Since the 2010s, there has been a shift in popular culture regarding body positivity (Cohen, Newton-John, Slater 2021; Streeter 2023). There are limitations to the body positive movement and thinness is still a socially desirable physique, but there has been a reduction in blatant anti-fat attitudes that were present in the 1990s and 2000s. While my participants often expressed feeling like they were targets of anti-fat bias or that they cared about their weight mainly for health reasons, participants may have held socially undesirable views about fatness that were less willing to openly share. Additionally, participants could see my profile picture on my Facebook profile and, also in the case of video-conferencing interviews, were able to see that I am a fat, white person which could have impacted participant responses. Participants who were fat may have connected with me more because of my fat body but the perception of being in the in-group means that they could have assumed I knew more or shared their experiences, potentially leaving information unsaid. Also, through snowball sampling and initially reaching out to fat acquaintances and friends, my sample of fat parents may have been more aware and critical of

anti-fat stigma, which potentially shaped the results of how fat parents respond to weight stigma over the course of becoming a parent. Thin participants, on the other hand, may have altered their answers at the risk of offending me and provided more socially desirable answers, especially in an age of "body positivity," which may have impacted how forthright they chose to be about their perspectives on weight gain.

Finally, as all interviews were done via videoconferencing and over the phone, important data is lost, particularly body language and building rapport with participants can be limited. While phone and videoconferencing interviews are useful and can provide flexibility and comfort to participants, interview methods, and studies on bodies in particular, benefit from a more embodied interview method, taking into consideration both the researcher and participant's body language (Ellingson 2017). Interview notes also become field notes that can be taken into consideration during the coding process. While my participants are not generalizable, or representative, to all parents, this does not diminish the importance and value of the findings. My work exemplifies the importance of understanding the complex and nuanced social location of parents and contributes to an in-depth analysis of parenthood in relation to embodied experiences. Future research will benefit from the theorization I have provided and can work toward further connection of life course and sociology of the body.

Future Directions

Bodies will continue to be highly nuanced, contextual, complicated, and deserving of future study. We all have a body and experience our embodiment in a world that regularly frames bodies as dysfunctional, abnormal, and in need of alterations. But bodies are not and will never be universal. I have attempted to draw connections and differences amongst my participants' *bodies* rather than framing *the body* as a ubiquitous concept. Utilizing the

theorization of *liminal embodiment*, more research can be done to examine the transitional nature of bodies through various social locations, transitions, pathways, and institutions and recognize the intersectional nature of bodies.

This work would benefit from a further discussion about gendered and racialized fatness. I have chosen to focus on the transitional nature of bodies, organizing my findings through an examination similar to previous research looking at parenting through the process of prenatal, natal, and postnatal experiences. However, fatness is gendered, raced, and classed but these analyses are currently beyond the scope of this project. While I examine parenting from a gendered perspective, more is needed regarding body size. Future research should include more direct questions and analysis about how participants experience their changing body size in relation to their race, gender, and socioeconomic backgrounds. Previous research has examined the ways in which anti-fatness is rooted in anti-Blackness (Sanders 2019; Strings 2019), threatens racial power of whiteness (Rennels 2015; Sanders 2019), and creates gendered barriers to fat men and women, such as feminizing fat men (Whitesel 2014; White 2020). These are all important considerations for research on bodies in transition within and between different institutions.

This project is only a snapshot of participants' experiences and relies on retrospective interview methods. Retrospective interview methods are helpful for understanding how participants construct, recall, and understand their worldview and lived experiences. However, future research could provide a more longitudinal and ethnographic approach. Rather than relying on only interview methods, accompanying expectant parents to medical appointments would shed additional light onto how parents choose and interact with their health care providers and how they perceive their changing body in the moment. Using an ethnographic approach

would also help in further examination of interpersonal relationships, especially with health care providers, which would build on medical sociology and sociology of the body research regarding sexism, racism, and weight stigma in medical institutions.

Researchers examining the body will benefit from the recognition that bodies, like social status and roles, are always in transition. Transitions of bodies are also complicated and nuanced, deserving more consideration into how individuals perceive positive or negative outcomes in social pathways, even if their body may lead them to socially or physically non-normative pathways (such as the social implications of weight gain or infertility). Additionally, beyond academic research, weight discrimination language can be included in social policies and laws, and medical institutions can improve treatment of patients through weight discrimination training. Currently, only one state, Michigan, prohibits weight discrimination (Sabharwal et al 2020; Tremont 2023). Research has shown that while training and education on weight discrimination can lead to short term changes in anti-fat attitudes, these changes are not long term (Sherf-Dagan 2022). These initial efforts will go a long way in reducing weight-based stigma and can further the conversations about Reproductive Justice.

Conclusion

Parenthood is one of the most surveilled and simultaneously taken for granted positions, where parenthood is constructed as a normative pathway for most people and choosing not to have children is considered abnormal. As individuals transition into parenthood, their bodies and lifestyles become hyper-surveilled through a medical model which constructs their ability to be a good and fit parent in connection with their body's ability to "function" appropriately (i.e. gestation, breastfeeding).

As more and more people choose to be childfree or are having children later than previous generations (Adamy 2023; Grabmeir 2023), family and parenthood remains as one of the most important and foundational social institutions and social transitions. Parenthood has implications for how individuals are viewed as achieving adulthood and having more responsibility. Parents embody neoliberal ideologies that put undue stress on them as they navigate messages that their children, their parenting, and their bodies are not good enough. Parents are challenging these messages but find it hard to do so against friends, family, and institutional actors who can create barriers through denial of services or implicit or explicit discrimination.

As the world grapples with changing social norms and concerns about children, we can start with supporting parents in their transition into parenthood. Parents are really trying to do their best in a society that puts immense pressure on them to raise their children well, maintain the health of themselves and their family, and to look good doing it. Happy parents will produce happy children, and providing them with the services, opportunities, and grace they need will go a long way in changing how we view the transition into parenthood.

APPENDIX

Appendix A: Institutional Review Board Approval

Date: 2-14-2024

IRB #: 1745514-2
Title: Contemporary Experiences of Parenthood
Creation Date: 8-31-2021
End Date: 4-8-2024
Status: Approved
Principal Investigator: Elizabeth Lawrence
Review Board: Social/Behavioral
Sponsor:

Study History

Submission Type Legacy	**Review Type** Unassigned	**Decision**
Submission Type Modification	**Review Type** Exempt	**Decision** Exempt
Submission Type Modification	**Review Type** Exempt	**Decision** Exempt

Key Study Contacts

Member Elizabeth Lawrence	**Role** Principal Investigator	**Contact** elizabeth.lawrence@unlv.edu
Member Torisha Khonach	**Role** Primary Contact	**Contact** khonach@unlv.nevada.edu

Appendix B: Phase I Interview Schedule

Interview Schedule for "Contemporary Experiences of Parenthood"

The interviews will be semi-structured, and thus will not follow a strict script. I will begin each interview by asking "How many children do you have" and "Please tell me about your child/children". I intend to ask intentionally open-ended questions to let the interviewees guide the direction of the interview as much as possible, with me asking follow up questions such as 'Can you talk more about that?' or 'Could you give me a specific example when something like that happened?' Possible topics that I anticipate will come up include:

1. **How many children do you have?**
    a. **Biological**
    b. **Adopted**
    c. **Foster**
2. **Please tell me about your child/children.**
3. **When did you first begin wanting to become a parent?**
    a. **Age**
    b. **Why that age?**
4. **When did you actively start trying to become a parent?**
5. **At what age did you become a parent?**
6. **What did you do to prepare for parenthood?**
    a. **Read books**
    b. **Changed eating habits**
    c. **Changed activity habits**

d. **Talked with partner**

7. **Did you choose to tell others you were trying to become a parent?**
    a. **Family**
    b. **Friends**
    c. **Kept it to self**
8. **What were some of your worries about getting**
    a. **Pregnant**
    b. **Adopting**
    c. **Fostering**
9. **Please tell me about your experiences trying to get pregnant:**
    a. **W/ Doctors**
    b. **Family**
    c. **Friends**
    d. **Strangers**
    e. **Work**
10. **When you became a parent, did you feel prepared?**
11. **Do people treat you differently now that you are a parent?**
    a. **Your parents**
    b. **Doctors**
12. **Please tell me about your experiences… now that you are a parent**
    a. **W/ Doctors**
    b. **Family**
    c. **Friends**

d. **Strangers**

e. **Work**

13. What are/were some of your primary concerns about raising children?

a. **School**

b. **Family**

c. **Activities**

d. **Wellbeing**

14. Have you ever felt judged as a parent by:

a. **Family**

b. **Doctors**

c. **Social workers**

d. **Your children's teachers**

e. **strangers**

15. When did these incidents occur?

a. **Your age?**

b. **Your children's age?**

c. **Where?**

d. **What happened?**

16. How did you manage these incidents?

17. How do you feel you have been emotionally since becoming a parent?

18. How do you feel physically since becoming a parent?

19. What other challenges have you experienced being a parent?

20. How would others describe you as a parent?

21. What do you think you do well as a parent?

22. How old are you?

23. What is your race?

24. What is your gender?

25. What is your sexuality?

26. What is your relationship status?

27. How old are you?

28. What is your occupation?

Appendix C: Phase II Interview Schedule

Interview Schedule for "Contemporary Experiences of Parenthood"

The interviews will be semi-structured, and thus will not follow a strict script. I will begin each interview by asking "How many children do you have" and "Please tell me about your child/children". I intend to ask intentionally open-ended questions to let the interviewees guide the direction of the interview as much as possible, with me asking follow up questions such as 'Can you talk more about that?' or 'Could you give me a specific example when something like that happened?'

I will tell my participants that the first section is about their experience becoming and being a parent. I will then tell them that the second part of the interview will focus on their own understanding and experience of their body throughout the course of being a parent.

Possible topics that I anticipate will come up include:

Part 1: Children and Parenting

1. How many children do you have?

a. Biological

b. Adopted

c. Foster

2. Please tell me about your child/children.

3. When did you first begin wanting to become a parent?

a. Age

b. Why that age?

4. When did you actively start trying to become a parent?

5. At what age did you become a parent?

6. What did you do to prepare for parenthood?

a. Did you read any books when you were trying to become a parent?

b. Did you change your eating habits?

c. Did you change the activities you did?

d. Did you have conversations with your partner prior to becoming a parent?

7. Did you choose to tell others you were trying to become a parent?

a. Family, friends

b. How did you choose who to tell?

8. What were some of your worries about becoming a parent?

a. What were some worries you had mentally?

b. What were some worries you had physically?

9. Please tell me about your experiences trying to become a parent:

a. Did you use any technology? (apps, OPKs, temprature)

b. If so, how did you feel using these products?

c. If not, why not?

10. When you became a parent, did you feel prepared?

11. Do people treat you differently now that you are a parent?

12. Please tell me about your experiences now that you are a parent

13. Have you ever felt judged as a parent?

14. When did these incidents occur?

15. How did you manage these incidents?

16. What drew you to this study?

Part 2: Parental Body

17. Do you feel your body was judged before/during becoming a parent?

18. Do you feel your body has been judged differently since becoming a parent?

a. How do you respond to these judgements?

b. How do you manage these incidents?

19. How would you describe your body prior to becoming a parent?

20. How would you describe yourself physically?

21. How would you describe your body?

22. What are some ways your body has changed?

23. How do you feel about these changes?

24. How do you feel physically since becoming a parent?

25. What other challenges have you experienced being a parent?

26. How would others describe you as a parent?

27. What do you think you do well as a parent?

28. What is your age?

29. What is your race?

30. What is your gender?

31. What is your sexuality?

32. What is your relationship status?

33. What is your education status?

34. What is your occupation?

Appendix D: Recruitment Flyer

AN INVITATION TO PARTICIPATE

IN A SOCIOLOGICAL STUDY ABOUT PARENTHOOD AND BODIES

Title of Study: Contemporary Experiences of Parenthood

Student Investigator:

Torisha Khonach, M.A. University of Nevada, Las Vegas, Department of Sociology

Email: torisha.khonach@unlv.edu Phone: (707) 278-9499

Principal Investigator:

Elizabeth Lawrence, PhD, University of Nevada, Las Vegas, Department of

Sociology Email: elizabeth.lawrence@unlv.edu Phone: (702) 895-0538

- Do you have biological, adopted, and/or foster children?
- Are you 18 years of age or older?

If you answered yes to these questions, and would like to participate in this research study, please contact Torisha Khonach, Graduate Student of Sociology, at the University of Nevada, Las Vegas at torisha.khonach@unlv.edu or by phone [707-278-9499] to schedule an interview at your convenience.

All interviews are conducted over the telephone or through Google Meet and are completely confidential.

Interviews will last approximately 60 minutes. Any identifiable information will not be revealed or used in the analysis or publication of this research. While the telephone interviews will be audio-recorded, the audio recording will be destroyed after transcription. If you prefer, you may elect to participate in this study without being audio-recorded.

Would you please share this invitation with your personal and professional networks?

Thank you!

Torisha Khonach, M.A.
torisha.khonach@unlv.edu
phone number: 707-278-9499

Appendix E: Verbal Consent Form and Information Sheet

EXEMPT RESEARCH STUDY

INFORMATION SHEET

Department of Sociology

TITLE OF STUDY: Contemporary Experiences of Parenthood

INVESTIGATOR(S) AND CONTACT PHONE NUMBER: Torisha Khonach (707-278-9499) and Elizabeth Lawrence (702-895-0538)

The purpose of this study is to explore contemporary experiences of parenthood and experiences of parents and their bodies. You are being asked to participate in the study because you meet the following criteria: you identify as a parent, including biological, adoptive, and fostering.

If you volunteer to participate in this study, you will be asked to do the following: participate in an audio-recorded telephone interview or a video and audio-recorded Google Meet virtual interview about your lived experience as a parent.

This study includes only minimal risks. The study will take 60 *minutes* of your time. You *will not* be compensated for your time.

For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted you may contact **the UNLV Office of Research Integrity – Human Subjects at 702-895-2794, toll free at 888-581-2794, or via email at IRB@unlv.edu.**

Your participation in this study is voluntary. You may withdraw at any time. You are encouraged to ask questions about this study at the beginning or any time during the research study.

Verbal Participant Consent:

Do you agree that I just read this information to you?

Do you agree to participate in this study?

Are you at least 18 years of age?

[I will not continue to interview this participant unless the participant verbally replied "yes" to each of the three above questions.]

Where may I send you a copy of this information sheet? I can send you an electronic and/or a

hard copy.

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Washington Cole, Katie O., Kimberly A. Gudzune, Sara N. Bleich, Lawrence J. Cheskin, Wendy L. Bennett, Lisa A. Cooper, and Debra L. Roter. 2017a. “Providing Prenatal Care to Pregnant Women with Overweight or Obesity: Differences in Provider Communication and Ratings of the Patient-Provider Relationship by Patient Body Weight.” *Patient Education and Counseling* 100(6):1103–10. doi: 10.1016/j.pec.2016.12.030.

Weinbaum, Alys Eve. 2019. *The Afterlife of Reproductive Slavery: Biocapitalism and Black Feminism’s Philosophy of History*. Durham London: Duke University Press.

White, Francis. 2020. “Embodying the Fat/Trans Intersection.” Pp. 110–21 in *Thickening Fat: Fat Bodies, Intersectionality, and Social Justice*, edited by M. Friedman, C. Rice, and J. Rinaldi. New York: Routledge.

Whitesel, Jason. 2014. *Fat Gay Men: Girth, Mirth, and the Politics of Stigma*. New York: New York University Press.

Zajacova, Anna, and Elizabeth Lawrence. 2021. “Postsecondary Educational Attainment and Health among Younger U.S. Adults in the ‘College-for-All’ Era.” *Socius: Sociological Research for a Dynamic World* 7:1-13. doi: 10.1177/23780231211021197.

CURRICULUM VITAE

Torisha Khonach
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Last updated: 7 March, 2024

EDUCATION

2024 Ph.D. Candidate, Sociology, University of Nevada, Las Vegas
Dissertation: "Liminal Embodiment and the Changing Parental Body"
Committee: Elizabeth Lawrence (Chair), Cassaundra Rodriguez, Barb Brents, Sheila Bock

2018 M.A., Sociology, California Polytechnic State University, Humboldt
Thesis: "We Break Our Bodies to Save Our Souls: Identity Formation in Women's Flat Track Roller Derby" Committee: Renée Byrd (Chair) and Jennifer Eichstedt

2016 B.A., Sociology, California Polytechnic State University, Humboldt
Magna Cum Laude

2014 A.A., Humanities and Social Sciences, College of the Redwoods
Honors

SPECIALTY AREAS

Gender, Sex, and Sexuality, Race and Ethnicity, Body and Embodiment, Social Inequalities, Sociology of Health, Qualitative Research Methods

COMPREHENSIVE EXAM AREAS

Race and Ethnicity
Gender, Sex, and Sexuality

ACADEMIC POSITIONS

2024-current Assistant Professor, Department of Behavioral and Social Science, Los Angeles Trade-Technical College
- Introduction to Sociology
- Sociology of Gender
- Marriage and the Family

2019-2024 Instructor, Department of Sociology, University of Nevada, Las Vegas
- Introduction to Sociology
- Sociology of the Body

2018-2021 Graduate Teaching Assistant, Department of Sociology, University of Nevada, Las Vegas
- Introduction to Sociology
- Men and Masculinities
- Gender & Society
- Research Methods

2017-2018 Instructor, Department of Math, Science, Behavioral and Social Science, College of the Redwoods
- Introduction to Sociology
- Death and Dying
- Environment, Culture, and Society

2016-2018 Graduate Teaching Assistant, Department of Sociology, Cal Poly Humboldt
- Fat Studies (co-instructed with Dr. Meredith Williams)
- Introduction to Sociology
- Race and Inequality
- Research Methods
- Classical Social Theory
- Sociology of Altruism and Compassion
- Sociology of the Changing Family
- Sex, Class, and Culture (online)

RESEARCH POSITIONS

2021-2022 Research Assistant, Department of Sociology, University of Nevada, Las Vegas
Locating and annotating relevant scholarly research

2020-2021 Research Assistant, Department of Sociology, University of Nevada, Las Vegas
Coding, thematic analysis

2017-2018 Research Assistant, Department of Sociology, Cal Poly Humboldt
Conducting interviews, coding, presenting findings

2016 Research Assistant, Department of Sociology, Cal Poly Humboldt
Co-facilitated focus groups

PUBLICATIONS

*Undergraduate researcher

2024 Khonach, Torisha and Anna Kurz*. "Challenges of #bodypositivity: Social Media and Hashtag Activism" *Fat Studies: An Interdisciplinary Journal of Body Weight and Society* 1-21.

2022 Khonach, Torisha. "Feminine Negotiations and Patriarchal Bargains: Contradictory Resistance in Women's Flat Track Roller Derby" *International Review of the Sociology of Sport* 58(6): 1014-1029.

2020 Davis, Georgiann and Torisha Khonach. "The Paradox of Positionality: Avoiding, Embracing, or Resisting Feminist Accountability." *Fat Studies: An Interdisciplinary Journal of Body Weight and Society* 9(2): 101-113.

PUBLICATIONS and PROJECTS IN PROGRESS

Khonach, Torisha. "'My Body was Made to Produce this Child': Constructions of Natural and Normal Pathways to Parenthood" (Status: Writing)

Khonach, Torisha. "Looking Fatter and Not Pregnant: Body Size as Medicalizing Factor in Parenting" (Status: Writing)

SCHOLARSHIP, FELLOWSHIPS, and AWARDS

2024 James Frey Scholarship, UNLV Sociology- $1000
Graduate and Professional Student Association Travel Grant, UNLV $2500

2023 Beth B. Hess Memorial Scholarship, SWS- $18000
Doctoral Finishing Fellowship, UNLV- $12000
Summer Doctoral Research Fellowship, UNLV- $7000
Donald Carns Scholarship, UNLV- $980
Graduate and Professional Student Association Award, 2nd place UNLV- $350
Outstanding Sociology PhD Student award, UNLV Sociology

2022 Summer Doctoral Research Fellowship, UNLV- $7000
Patricia Sastaunik Scholarship, UNLV- $2500
Graduate and Professional Student Association Travel Grant, UNLV $2500
Inspiration, Innovation, and Impact Research Award, UNLV-$1500
Outstanding Graduate Student Teaching Award, 1st place UNLV- $2500
Graduate and Professional Student Association Award, 1st place UNLV- $500
Outstanding Graduate Student Paper Award, UNLV Sociology
Outstanding Graduate Student Teaching Award, UNLV Sociology

2021 Intersection First-Generation Essay Contest, 2nd place UNLV- $300
Rebel Grad Slam Finalis,t UNLV- $500

2016 James and Sara Turner Sociology Scholarship, Cal Poly Humboldt- $1500

2014 Student Leadership Award, College of the Redwoods- $500

CONFERENCE PRESENTATIONS

*Undergraduate researcher

2023 "Parenthood as a Reprieve: The Liminal Moment of Weight Gain Approval"
Accepted to American Sociological Association, Philadelphia, PA
"'My Body was Made to Produce this Child': Constructions of Natural and Normal Pathways to Parenthood"
Eastern Sociological Society, Baltimore, MD.
UNLV GPSA Research Forum, Las Vegas, NV
"Looking Fatter and Not Pregnant: Shaping the Parenting Body"
Pacific Sociological Association, Bellevue, WA.
UNLV GPSA Research Forum, Las Vegas, NV
Khonach, Torisha and Anna Kurz*. "'Don't Be So Hard on Yourself When Your Body Changes Too': Social Media, the Ideal Body, and #BodyPositivity"
Pacific Sociological Association, Bellevue, WA
UNLV GPSA Research Forum, Las Vegas, NV

2022 "Feminine Negotiations and Patriarchal Bargains: Contradictory Resistance in Women's Flat Track Roller Derby."
American Sociological Association, Los Angeles, CA.
"Fit Parents: Mapping Neoliberalism onto the Parenting Body."

Pacific Sociological Association Annual Conference, Sacramento, CA.

"Fit Parents: Mapping Neoliberalism onto the Parenting Body."

UNLV GPSA Research Forum, Las Vegas, NV

"Healthism and Parental Embodiment"

Inspiration, Innovation, and Impact: A Celebration of Graduate Student Research, Las Vegas, NV

2020 "Weight Limits Apply: Lawful Medical Violence and the Fat Body."

Accepted to present at the Pacific Sociological Association Annual Conference, Eugene, OR. (Cancelled due to COVID-19)

2019 "Too Fat for the Classroom: How Institutions of Higher Education Reproduce Fatphobia."

Pacific Sociological Association Annual Conference, Oakland, CA

2018 "Burlesque Meets Badass: The Negotiation of Femininity in Women's Flat Track Roller Derby"

Pacific Sociology Association Annual Conference, Long Beach, CA.

2017 "We Break Our Bodies to Save Our Souls: Identity Formation through Participation in Women's Flat Track Roller Derby"

Pacific Sociology Association Annual Conference, Portland, OR.

2016 "Content Analysis of Sexual Assault Prevention Education Across the California State University System"

Pacific Sociology Association Annual Conference, Oakland, CA.

Cal Poly Humboldt Institute for Student Success, Arcata, CA.

PROFESSIONAL DEVELOPMENT

2023 Graduate College and University Ambassador, UNLV
Research and Mentoring Program, UNLV
Graduate Mentorship Certification, UNLV

2022 Grant Writing Seminar, Cal Poly Humboldt
Graduate Teaching Certification, UNLV
Graduate Research Certification, UNLV

2021 Accessible Syllabus Training, UNLV
Soc 709 Teaching Sociology, UNLV

2020 Online Teaching Essentials, UNLV
Soc 710 Teaching Practicum, UNLV

2019 Online Teaching and Learning Training, CR

2018 Graduate College Teacher Training and Workshop, UNLV

2016 Soc 560 Teaching Sociology, Cal Poly Humboldt

SERVICE

Disciplinary Service

2023-2024 SWS-West Coordinator, Sociologists for Women in Society

2022-2023 Graduate Student Co-editor, ASA Section on Medical Sociology Newsletter

2021-2022 Graduate Student Representative, ASA Section on the Sociology of Body and embodiment

Communications Committee

Programs Committee (Roundtable Organizer)

2019-2023 Web Master, ASA Section on the Sociology of Body and Embodiment

2019 Proofed and edited chapter exercises in Social Statistics for a Diverse Society 9th edition

University Service

2023-2024 Graduate and Professional Student Association Sponsorship Committee, UNLV Vice-Chair

Graduate Student Representative to Faculty, UNLV Sociology

2023 Graduate and Professional Student Association Sponsorship Committee, UNLV

2021 Social Inequalities Hiring Committee, UNLV Sociology

2019 Community Affairs Committee, UNLV Sociology

2017-2018 Lead Graduate Teaching Assistant, Cal Poly Humboldt

2016-2018 Sociology Graduate Student Representative and Liaison, Cal Poly Humboldt

2016-2017 Peer Health Educator, Cal Poly Humboldt

2016-2017 Title IX Outreach Committee, Cal Poly Humboldt

2014 Consent Centered Safe Sex workshops, College of the Redwoods

2013 "Campus Dialogue on Rape Culture" Bi-Weekly campus discussion, College of the Redwoods

Public Sociology and Community Engagement

2021-2022 The LGBTQ Center Community Health Clinic, Las Vegas, NV

2016-2018 Humboldt Roller Derby, Eureka, CA

2012-2016 Humboldt Pride Organization, Eureka, CA

PROFESSIONAL MEMBERSHIP

American Sociological Association

Pacific Sociological Association

Eastern Sociological Society

Society for the Study of Social Problems

Sociologists for Women in Society

Alpha Kappa Delta

Phi Kappa Phi