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The Weight of the Interaction: An Exploration of Fat Women's Experiences in Healthcare Settings

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THE WEIGHT OF THE INTERACTION: AN EXPLORATION OF FAT WOMEN'S EXPERIENCES IN HEALTH CARE SETTINGS

Danielle Snow, M.A.

Western Michigan University, 2022

Despite making up a large portion of the United States population, fat people are stigmatized, discriminated against, and treated as deviant. Though there is a large body of interdisciplinary literature on *obesity* and health, and a large body of sociological literature on stigma, there is little literature on fat stigma. Thus, using a Goffman's stigma theory with the added contribution of Foucault's concept *the medical gaze* and medical anthropological concept *delegitimization*, this qualitative thesis explores the health care experiences of 13 White and 2 Black fat women in the U.S. First, context for fatness and health is explored within chapter four. Here, language, meaning, and social understanding of fatness is explored. Next, the health care process is explored. This begins with a description of the preparation involved in "gearing up" for appointments. Then, there is an exploration of both the negative and positive of these visits. Finally, the analysis concludes with what comes after an appointment ends for these fat women. Particular attention is paid to both how stigmatization is enacted against fat women via the hands of health care authorities, and the ways in which fat women respond to and cope with this stigmatization.

THE WEIGHT OF THE INTERACTION: AN EXPLORATION OF FAT WOMEN'S
EXPERIENCES IN HEALTH CARE SETTINGS

by

Danielle Snow

A thesis submitted to the Graduate College
in partial fulfillment of the requirements
for the degree of Master of Arts
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Danielle Snow

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CHAPTER I: INTRODUCTION

To live within a fat body is to live within a stigmatized body. Despite making up around one-third of the nation (Flegal, Carroll, Ogden, and Curtin 2000; U.S. Department of Health and Human Services and Department of Agriculture 2020), fat people are frequent targets of derogatory comments, prejudicial assumptions, and overall negative social treatment (Lee and Pausé 2016). The stigmatization of the fat body is both produced and maintained by many social institutions within the U.S. such as family (Ogden and Clementi 2010; Puhl and Brownell 2006), media and entertainment (Farrell 2011; Himes and Thompson 2007), and within medicine (Phelan, Burgess, Yeazel, Hellerstedt, Griffin, and van Ryn 2015). Furthermore, fat stigma is a common component of interactions among friends (Puhl and Brownell 2006; Puhl and Latner 2007), co-workers (Puhl and Brownell 2006; van Amsterdam and van Eck 2019), classmates (Puhl and Brownell 2006), and teachers (Puhl and Latner 2007). Navigating stigmatization and discrimination are routine in the daily lives of fat Americans (Lee and Pausé 2016).

Negative stereotypes are violently thrust upon the fat body, both historically and contemporarily. Unlike some other attributes that conceal easily, fatness is hypervisible (LeBesco 2011; Murray 2005). This positions fat people for increased vulnerability to judgment, discrimination, and unsolicited weight loss recommendations (Brewis 2014). The poor treatment of fat people is not exclusive to social settings. Instead, this violence is also perpetuated within clinical settings (Phelan et al. 2015). Both practicing health care professionals (Phelan, Dovidio, Puhl, Burgess, Nelson, Yeazel, Hardeman, Perry, and van Ryn 2015; Poon and Tarrant 2009; Sabin, Marini, and Nosek 2012) and medical students (Phelan et al. 2014; Poon and Tarrant 2009) have been found to have anti-fat bias impact their treatment of fat patients. Additionally,

both narrative accounts (see Meeraai 2019; Murray 2008) and empirical studies (see Vartanian 2010) provide evidence on how disgust, anger, blame, and skepticism are all common attitudes directed at and felt by fat people when attending health care visits.

The fat body has been medically pathologized as diseased (Oliver 2006; Saguy 2013). This has led to the dehumanization of fat people both within and outside of medical institutions. For example, there is evidence to argue that medical authorities such as doctors or nurses view and treat visits with fat patients as a waste of time (Bleich, Pickett-Blakely, and Cooper 2011; Ferrante, Fyffe, Vega, Piasecki, Ohman-Strickland, and Crabtree 2010; Hebl and Xu 2001) because they assume that fat patients do not care about their health (Ferrante et al. 2010). Furthermore, medical personnel are more likely to suggest weight loss and lifestyle changes to their fat patients than they are to explore other treatment options (Halbert, Jefferson, Melvin, Rice, and Chukwuka 2017; Meeraai 2019; Murray 2008). Lifestyle advice comes from the mouths of many individuals within fat peoples' lives including health care professionals, family, friends, and even strangers (LeBesco 2011). Ironically, researchers have shown that the concern with *obesity* and fat bodies has very little to do with someone's health status (Campos 2004; LeBesco 2011; Strings 2019).

Researchers of a 2016 study found half of people who are categorized as “overweight” and “obese”¹ were determined to be cardiometabolically healthy regardless of their BMI (Tomiyaama, Hunger, Nguyen-Cuu, and Wells 2016). Additionally, their data analysis concluded that 30% of individuals within a “normal” BMI range were not cardiometabolically healthy. Ultimately, they conclude that cardiometabolic health statuses cannot be assumed based on weight or BMI

¹ This study used BMI standards to categorize the weight status of their research participants.

(Tomiyama, Hunger, Nguyen-Cuu, and Wells 2016). Though cardiometabolic health is not the only metric considered when conceptualizing one's health status, heart health is often assumed to be nonexistent for fat people. Thus, having research to challenge this prejudicial assumption is important for improving the quality of health care appointments for fat people. These researchers said, "For these individuals [fat people], having a health care provider prescribe weight loss could be a misuse of time, patient effort and resources" (Tomiyama, Hunger, Nguyen-Cuu, and Wells 2016: 884).

Furthermore, advice such as dieting or weight loss surgery, whether it comes from a professional or not, tends to encourage unhealthy behaviors or mindsets for the sake of a thin appearance (LeBesco 2011; Saguy 2013; Throsby 2008). This implies that the social problem with fatness has much less to do with health, and much more to do with morality and social standards for bodies. As law professor and author, Paul Campos said in his 2004 book *The Obesity Myth*, "Americans love to moralize about fat because, among other reasons, fat has become a convenient stand-in for various characteristics that have been traditionally associated with the pariahs of the moment" (Campos 2004: xxiii). Campos is getting at the linkage among oppressive ideologies, and what he is really saying is that fat stigma is not merely about weight. While there have been certain time periods when fat has been viewed as fashionable, such as the late nineteenth century when wealthy German immigrant women's fleshiness influenced American elite for a brief period (Saguy 2013; Strings 2019), fatphobia has had a longer-lasting history and a larger impact on contemporary social interactions (Saguy 2013; Strings 2019; White 2019).

Returning to Campos' (2004) perspective, he plainly states that in the U.S., the fat body has been made to represent a multitude of social issues and "failures." One such issue is the assumed

lack of self-governance. Fatness, according to negative social perspectives, could not exist if the individuals in these fleshy bodies were rigidly disciplined. Where fatness socially and morally represents gluttony and barbarity, thinness has historically signified self-control and civility (Saguy 2013; White 2019). Even more than self-governance, there is a racialized component of fatness. Ultimately, the fat body is a threat to the thin, White, ideal American image (Farrell 2011; LeBesco 2011; Saguy 2013; Strings 2019). This is the foundation of sociology, Dr. Sabrina Strings' 2019 book *Fearing the Black Body: The Racial Origins of Fat Phobia*. Here, Strings (2019) unveils just how fatphobia is inextricably tethered to anti-Black racism and White supremacy. In this scholarly work, Strings uses critical historical and sociological analysis to examine the purpose of fatphobia as not only a means of disciplining White women's bodies, but also as a means of systemically penalizing Black women's for not meeting White standards. As Strings (2019) and other researchers argue, the issue with fat bodies is not merely that they are fat. Rather it is what the fat body socially represents that is the foundation of fat stigma. All of which leads fat people, especially fat peopled with further marginalized identities, to be treated as non-normative, inferior, and threatening.

Though fat people are forced to navigate fat stigma throughout their daily lives, it is erroneous to assume that being fat is a homogenous experience (Pausé 2014; White 2019). For example, a fat woman who wears a size 18 will have different experiences than a woman who wears a size 28. Additionally, to be fat, White, and cisgender imparts a starkly different life than being fat, Black, and transgender. Fat stigma and the consequential oppressions that stems from it are deeply entangled in other social oppressions such as racism, sexism, homophobia, transphobia, classism, and ableism. There is also a magnificent "messiness and fleshiness" (Rinaldi, Rice, and Friedman 2019:3) to the way identities intersect and create one's lived

experience. To ignore the way fatness “explode[es] expectations of gender, race, coloniality, disability, and madness” (Rinaldi et al. 2019:6) would leave my research lifeless and hardly useful.

Purpose and Research Questions

Too often fat people are left out of research. Our² opinions are dismissed, determined to be unworthy, unnecessary, and aberrant. Thus, there are many questions to ask fat people and many stories to hear. The purpose of this research, though, is to ask and find the answers to the questions: what happens in health care visits for fat women and how do they cope with stigma within medicine? While there is much evidence to claim that anti-fat bias is common within health settings (see Phelan et al. 2015) and there is also some research on fat patient stigmatization (see Lewis, Thomas, Warwick Blood, Castle, Hyde, and Komesaroff 2011), at the time of writing this, there is no detailed literature on fat patients’ perception of their health care process such as the preparation conducted before an appointment, the care process one might take afterward, and how they respond to, or do not respond to, stigmatization from medical authorities. Therefore, I am aiming to unveil the experiences of fat individuals in the U.S. seeking health care.

Despite the existence of Fat Studies as an academic area of research and scholarship, there is still much to be learned about fat peoples’ struggles, accomplishments, and lives, broadly. Though we might make numerous assumptions about what we *think* fat stigma looks and feels like within medical encounters, there is still much to learn. Thus, this research will describe the overall health care process for fat patients in the U.S., with specific attention paid to

² I explicitly say “our” here and in other parts of this written work because as a fat researcher, much of this research speaks to my own experiences as well.

stigma management strategies. This research will offer a better understanding of the discrimination fat people experience, and the forms of conformity, resistance, and avoidance that fat people engage in, in the face of stigmatizing medical settings, systems, and authorities.

I am interested in answering questions that pertain to three interrelated categories. The first question I ask is how do fat patients prepare for their health care appointments? How have their prior experiences navigating health care influence how they physically, emotionally, and intellectually compose themselves for their visits? Ultimately, what I am trying to get at here is an unveiling of fat patient's health care-based fears and ways they seek control over their treatment. Second, I concern myself with the more institutional issues within health care as they relate to fat patient treatment. Initially, I broadly asked the question, what are fat patients' experiences in health care settings? Throughout this research process, this question has transformed into in what ways does the institution of medicine reproduce and perpetuate stigmatization onto fat patients? Finally, I consider the aftermath of these appointments for fat patients. What happens after fat patients' health care visits? Furthermore, how do fat people understand their experiences of stigmatization that come from the hands of medical authorities and how do they manage these experiences?

CHAPTER II: LITERATURE REVIEW

Fat: A Medical Problem and National Epidemic

In an advice book on hygiene and health published in the early 1600s, and for the first time in known history, Tobias Venner used the word “obesus” to describe surplus fat on the human body (Gilman 2004; Strings 2019). Through history, this word transformed into the contemporary U.S. term, *obesity*. Venner coined and conceptualized “obesus” in order to bolster his argument that individuals could experience negative health consequences due to “excess” body weight (Gilman 2004; Strings 2019). Here we have the beginning of the idea that if humans want to live longer, we must try to be thinner.

Efforts towards equating thinness with optimal health has influenced health care, social treatment, and even health insurance. Regarding this latter part, in the 1940’s the Metropolitan Life Insurance Company (MetLife) developed their own index to identify “desirable weight” for their policyholders (Campos 2004; Gordon 2020). The outcome of the index per individual policyholder would determine the cost of insurance. Their index formula was simple, vague, and biased (Gordon 2020). According to MetLife, “desirable weight” was based on the height and “frame” of an individual. These frames were described as “small frame,” “medium frame,” and “large frame.” However, these categories were left undefined (Gordon 2020). Thus, while MetLife and other insurers (Gordon 2020) used this index, there was no medical standard associated with it. In fact, it has been described by others as “arbitrary, random, and meaningless” (Campos 2004: 9). In essence, this tool was used as a way of charging customers more and perpetuated the fear that fat was an earlier killer (Gordon 2020).

Although this index is not in use today, this isn’t because there is dearth in arbitrary weight assessment tools. Instead, these insurance tables were merely replaced with the Body

Mass Index (BMI). First developed in the early-to-mid-1800s, BMI is a weight-for-height index used in the U.S. for all ages and genders. The equation for calculating BMI is weight in kilograms divided by height in meters squared (Gordon 2020; Saguy 2013). Before being known as the Body Mass Index, the BMI was called the Quetelet Index (Eknoyan 2007). The index was developed in the 1830's by Belgian sociologist, astronomer, and statistician, Lambert Adolphe Jacques Quetelet. In search of *l'homme moyen* – an idealized average man – Quetelet gathered and assessed the measurements of different populations in search of a “universal average.” As Gordon (2020) described, “*L'homme moyen* was Quetelet's way of determining bodily perfection for the purpose of creating outside bodies, the contrasting forms that could be proclaimed diseased or disfigured” (Gordon 2020: 47). Important to note, Quetelet was not a member of the medical community nor was the BMI was never intended to be a metric of individual health. Instead, the index was intended for sociological use to assess populations (Gordon 2020).

Though a tool used by many health care professionals, the efficacy of the BMI is questionable and problematic at best (Gordon 2020). The index has limitations in that it is based on body weight, rather than body composition. This means the index cannot account for the difference in weight based on body fat versus muscle or bone size. Another extreme limitation is the lack of reliability for indicating the health status of people of color (Carroll, Chiapa, Rodriquez, Phelps, Cardarelli, Vshwanatha, Bae, and Cardarelli 2008; Gordon 2020; Shah, Vittinghoff, Kandula, Srivastava, and Kanaya 2015). As Gordon (2020) mentions, Quetelet was working when disciplines such as sociology and medicine were rife with racist and misogynist research³. Because his research primarily took place in Western Europe, the index focused on

³ Though, I and many others would argue that we are still working in disciplines that are rife with racist, misogynistic, and otherwise oppressive and discriminatory research.

predominantly white, non-disabled, male bodies. Thus, the BMI is less than adequate for many whose identities breach the limitations of this original sample. For example, researchers of a 2015 study determined Americans of South Asian descent who have BMIs within the “normal” range are two times more likely than white Americans with similar BMIs to have increased risk for heart disease, stroke, and Type 2 diabetes (Shah et al. 2015). Another example, researchers conducted a 2008 study where their data suggested that BMI and waist circumference do not adequately or accurately estimate the visceral fat accumulations in non-White racial and ethnic groups (Carroll et al. 2008). The inaccuracy of the tool for African American and Hispanic populations, compared to White populations, led researchers to suggest that different BMI cutoff points would be necessary for adequate reflection of health risk and body fat accumulation (Carroll et al. 2008). In essence, the BMI is not applicable for the global majority.

Nevertheless, even with these present problems associated with the BMI, the U.S. continues to use this tool. The standardized use of the BMI is relatively new, however. It wasn't until 1972 when researcher Ancel Keys and colleagues claimed the superiority of the BMI compared to other measurements (Keys, Aravanis, Blackburn, Van Buchem, Buzina, Djordjevic, and Taylor 1972). It was in this paper that Keys and colleagues re-named the Quetelet Index the Body Mass Index (Karasu 2017; Keys et al. 1972). Since then, the BMI has become a standard indicator for obesity and is used by many in the health care industry to help determine overall health status and risk. While this has remained true for half a century, the cut-off values of the BMI have become more rigid over the years.

As mentioned above, before the BMI was implemented, weight-for-height tables created by MetLife were used to distinguish desired weight classifications. These were used until the mid-1980s. This is because in 1980, the first edition of the Dietary Guidelines for Americans was

released. The publication of these guidelines was the beginning of the more formalized and standardized use of the BMI in the U.S. The guidelines specifically outlined the desired BMI was < 25 – 26 for men and < 24 – 25 for women. However, it wasn't until the 1984 report *Health in United States* that we saw a clear estimation for the BMI overweight cutoffs. Based on national prevalence estimates for overweight adults ages 25–74 years old, the cutoff became a BMI ≥ 28.0 for men. This meant anyone with a BMI range of 28 or higher was considered overweight (Kuczmarski and Flegal 2000).

Then in 1985, a Panel at the NIH Consensus Development Conference on the Health Implications of Obesity redefined the overweight and obese cutoffs for BMI for the sex categories male and female. This Panel defined overweight cutoffs as a BMI ≥ 27.8 for men and a BMI ≥ 27.3 for women (Kuczmarski and Flegal 2000; Van Itallie 1985). This was a quick shift from the *Health in United States* report, published less than two years prior, which just defined BMI overweight cutoffs at BMI ≥ 28.0 . Though these standards clearly imposed a sturdy line between those who were obese and those who were not, there was an understanding that a BMI of 27.8 or 27.3 was still not the desired weight for Americans. Though mentioned in the first edition of the Dietary Guidelines for Americans, the second edition released in 1985 made clear a BMI ≤ 25.0 was the desirable standard for American men and women (U.S. Department of Health and Human Services and Department of Agriculture 1985). This desire would come into play in future updates to the BMI and Dietary Guidelines.

Overall, these cutoffs remained relatively stable for the next decade. The BMI as a tool received slight updates such as the change in categorization by age and the combining of weight standards for sex categories (National Research Council (US) Committee on Diet and Health 1989; U.S. Department of Health and Human Services and Department of Agriculture 1990).

Then in 1995, the fourth edition of Dietary Guidelines for Americans implemented even more dramatic changes than what we saw in the 1980s. The guidelines said a BMI ≤ 25.0 was a healthy weight where now a BMI range of 25.0-28.9 was considered moderately overweight and a BMI ≥ 29.0 was severely overweight (U.S. Department of Health and Human Services and Department of Agriculture 1995). This decision, as many Fat Scholars have pointed out, “[caused] 29 million Americans to become overweight overnight” (Saguy 2013: 22-23). Though scientists, researchers, and fat activists disputed these changes, the decision remained (Saguy 2013).

Shortly after that, the World Health Organization (WHO) (1998) created new terminology and BMI cutoffs for classifying weight globally. These new classifications were underweight being a BMI < 18.5 , BMI 18.5-24.9 was normal weight, BMI ≥ 25.0 was overweight, BMI of 25.0-29.9 was preobesity, and class 1, 2, and 3 obesities were BMI of 30-34.9, 35.0-39.9, and ≥ 40.0 , respectively (Kuczmarski and Flegal 2000; WHO 1998). These measurements have had slight changes since then. The largest change was made in the fifth edition of the Dietary Guidelines for Americans where these cutoffs were condensed. Now, the U.S. BMI standards include underweight as BMI ≤ 18.5 , healthy weight as BMI ranging between 18.5-25.0, overweight as BMI ranging between 25.0-29.9, and obese as BMI ≥ 30.0 (U.S. Department of Health and Human Services and Department of Agriculture 2000; U.S. Department of Health and Human Services and Department of Agriculture 2020).

Though the BMI has been a tool used to categorize, and in many ways otherize, people in the U.S., this tool is not the start nor the end to what has been called *the obesity epidemic*. There are many theories as to the origins of the American obesity epidemic. Some point to food consumption (Eriksen and Manke 2011), others point to environment and lifestyle habits

(Eriksen and Manke 2011), even others point to poverty (Ernsberger 2009) and racial identity (Oliver 2006). While these ideas may offer a form of rationale for the rise in weight gain, they do not explain how obesity itself came to be understood as a national epidemic. According to J. Eric Oliver (2006), this modern pathologizing of fatness can be attributed to a single PowerPoint presentation given to members at the Centers for Disease Control and Prevention (CDC) in the mid-1990's. This presentation drastically changed both the American and global perceptions and definitions of fatness (Oliver 2006).

Before this presentation, the CDC had been collecting data on American people and their weight measurements for over 15-years via telephone surveys. The collected data, however, did not unnerve anyone. This was until the newly appointed Director of the Division for Nutrition and Physical Activity, William Dietz, took on his role in 1997. Through a personal interview, Oliver (2006) found out that Dietz entered this role with an anti-fat bias and thus the goal of eradicating obesity. So, in 1998, Dietz and colleagues came up with a calculated plan for presenting the CDC data. To convey their views on the severity of this obesity problem, Dietz and colleagues designed maps that outlined the rise in BMI rates across the different states in the U.S. over time. As BMI rates increased, the state's color transitioned from a light blue to a darker blue, to an alarming red. Rather than simply showing a trend, the maps conveyed something far more urgent— a spreading infection (Oliver 2006).

This method of data display proved more than effective. As Dietz made these illustrations public, different health care providers, government officials, policymakers, and academics began accessing the maps (Oliver 2006). Many individuals were quickly convinced that America's weight gain was indeed an epidemic. Following the distribution of the slides is the 1999 Journal of the American Medical Association's special issue devoted to obesity, which highlighted these

maps (Mokdad, Serdula, Dietz, Bowman, Marks, and Koplan 1999). Even the World Health Organization (WHO) reviewed Dietz's findings and incorporated them into global public health initiatives (Oliver 2006). Furthermore, countless headlines detailed the spread of the epidemic. The combination of startlement, threat, and fatphobia led to the proliferation of the “headless fatties,” a modern phenomenon marked by Fat Activist and scholar Charlette Cooper (2007). Cooper noticed “every speechifying press release about the ticking time bomb of obesity seemed to be accompanied by a photograph of a fat person, seemingly photographed unaware, with their head neatly cropped out of the picture” (2007: para 1). Since then, fat people have constantly been in the news. However, we are presented as dehumanized objects to gawk at, fear, and police. Cooper wrote, “As Headless Fatties, the body becomes symbolic. We are there but we have no voice, not even a mouth in a head, no brain, no thoughts or opinions. Instead, we are reduced and dehumanized as symbols of cultural fear: the body, the belly, the arse, food” (2007: para 3). The Headless Fatties, the stigmatization of the fat body, and the many more ridiculing, violent experiences felt by fat people have proved Dietz’s tactic worked within both medical arenas and the public.

These maps were alarming, compelling, and misleading. First, the maps insinuate there was a virus-like spread of obesity, as if it was something one could “catch” while sitting on a subway or if they didn't wash their hands well enough. In fact, in an article titled “Obesity is catching” the British Medical Journal (BMJ) said, “Obesity is a social disease that seems to spread through friends and families a bit like flu” (BMJ 2007). Messaging such as this perpetuates the fear that is rooted in fat stigma. Second, Dietz chose to use State boundaries rather than the size of the State's population to exaggerate the extent to which obesity was

impacting the U.S. (Oliver 2006). Nonetheless, the message still stood; there was an obesity epidemic, and it was something every American should fear.

We continue to see the perpetuation of this fat-based fear influence public health campaigns and messaging. For example in 2012, Georgia launched its Strong4Life campaign (Gordon 2020; Tovar 2018). This initiative aimed to reduce children's weight. As with most intentional weight loss public health campaigns, reports, and legislation, this initiative offered individualized and shameful recommendations over systemic solutions. This campaign used scare and shame tactics to end childhood obesity. One of the primary ways messaging about this campaign was distributed to the public was through eye-catching posters. These posters were in black-and-white and showed fat children staring out to their viewers. In red writing the word "WARNING" was seen at the bottom of the posters. Following this were different statements about fatness broadly or the characters these children were playing in these images. Some of the statements included, "It's hard to be a little girl if you're not," "Fat prevention begins at home. And the buffet line," and "Fat kids become fat adults" (Gordon 2020; Tovar 2018). Then in 2013, the American Medical Association (AMA) reconfigured obesity from a mere condition to a medicalized disease (Pollack 2013). In justification of this decision, AMA board member Dr. Patrice Harris made the statement, "Recognizing obesity as a disease will help change the way the medical community tackles this complex issue that affects approximately one in three Americans" (Pollack 2013: paras. 3). Harris' statement gave leverage to anti-fat medical treatments, public health campaigns, and encouraged Americans to further fear fatness.

There can be no doubt that fear is exactly what American people feel when it comes to fatness, and this fear leads to profit. In 2019, the weight loss and weight management/diet markets were valued at a combined \$192.2 billion. It is now projected to reach \$295.3 billion by

2027 (Vig and Deshmukh 2021). Despite years of searching for some cure, fix, or eradication of fatness, the truth is that no one really knows how to make and keep fat people thin (Campos 2004). However, the fear of getting fat and staying fat contribute to the growth of this market.

Throughout this section, the words “obese” and “obesity” were consistently used in place of other word choices such as fat or fatness. This was to recognize the medical terminology used to describe pathologized “excess” weight on the body. However, it should be noted that those medicalized words will rarely be used past this section. To borrow from author and the creator of the social media site and persona Your Fat Friend, Aubrey Gordon, “Obese is deceptively medical, regularly used by people whose concerns are anything but, and who are almost never doctors” (Gordon 2018). The use of the word obese is almost always derogatory, accompanied by dangerous lifestyle advice, and implies the superiority of the thin body. In contrast, the word “fat” has been reclaimed by many fat individuals, activists, and scholars (Cooper 2016; Saguy and Ward 2011). Fat is viewed as more matter of fact and as Gordon describes, “Does not claim anything my body is not, does not assign value unless I bestow it” (Gordon 2018).

The Medical Gaze & Anti-Fat Bias

Michele Foucault introduced and conceptualized the medical gaze as a sociological concept in his 1963 book *The Birth of the Clinic*, which outlines modern Western medical history. This concept refers to the assumed objective gaze that medical authorities use to assess their patient’s health status (Foucault [1963] 2003). A sinister consequence of the gaze is the dehumanization imposed upon health care patients as these medical authorities use their knowledge and power to separate a person’s identity from their body and construct them as an object for medical scrutiny. (Foucault [1963] 2003). What is lost is the social contexts of lives. This separation reduces an individual to their condition(s). This transforms the body from a place

on which disease is found, to a diseased body in and of itself. This gives medical authorities the power to impose interventions onto individual bodies (Linander, Alm, Hammarström, and Harryson 2017). These interventions violently subject medical patients to an objectification process, and for fat people, these interventions are also infused with stigma and discrimination (Kinavey and Cool 2019).

Prior to the emergence of the clinic and implementation of the medical gaze, a doctor would usually see patients in their homes and engage with a patient by asking “What is the matter with you?” (Foucault [1963] 2003: xviii). This gave space for and implied the necessity of dialogue where a patient could detail their experiences with their condition(s). As the age of the clinic took over, this question transformed into “Where does it hurt?” (Foucault [1963] 2003: xviii). This cut out the room for dialogue. Instead, patients merely said or pointed to where something hurt, and doctors would take over from there. This is because there was a shift in medical authorities’ interpretations of bodily signs of health and disease. Through the medical gaze, the human body is perceived less as a *human* and more as a multitude of overlapping systems with purposeful functions. Furthermore, a patient’s signs, symptoms, and stories are reconfigured to fit within a biomedical paradigm, or ignored completely, leaving most all non-biomedical data outside of the clinic walls. In essence, when a person walks into a health facility, their humanity is left at the door and their body is taken in as a specimen to be observed, diagnosed, and potentially treated (Foucault [1963] 2003). The adequacy and accuracy of this treatment, though, is not guaranteed, especially for fat people as mentioned below.

Foucault said that doctors and other medical workers have “a collective consciousness, with all the information that intersects in it, growing in a complex, ever-proliferating way” ([1963] 2003:29). In essence, medical authorities have exclusive knowledge to understand the

coded language of the overlapping systems of the human body. Therefore, when a human body enters the field of knowledge, or the clinical setting, itself a social space, it also enters a field of power. This then opens the body's potential to become a manipulated source of knowledge in its own sense (Foucault [1963] 2003). For example, there is a seemingly unwritten and unspoken social contract between a doctor and patient. Once the patient submits to medical treatment, the patient is obligated to honor the medical authority's expertise, including having their bodies treated as objects for presentation, control, and de-personalization.

The gaze and overall doctor-oriented approach, versus a patient-oriented approach, to health care has created an abusive power structure. Though patients may offer insight into their experiences with symptoms or medical history, Foucault informs us that it is the medical gaze offers medical authorities the legible signs of the body's interior systems. To be clear, a doctor using their medical gaze does not merely diagnose based on their immediate inspection of a patient. Rather, their gaze is a perception in which sight and language are of the same thing. In other words, none of this could happen within the medical gaze without the control of a "fine sensibility" ([1963] 2003:120). Foucault describes this "fine sensibility" as medical expertise characterized by the supposed lack of bias. According to Foucault ([1963] 2003), this sensibility comes from the trinity of sight, touch, and sound. As interpreted by author Samantha Murray:

in assessing a patient, a doctor must rely on his or her perceptions to know the patient: via the touch of fingers, the observation of lesions or (ab)normalities, the sounds of inner bodily functions: the medical expert positions the body of the other as either healthy or pathological (2008:34).

From a medical perspective, the body speaks to a health care provider through physical, visual, and audio signs. In essence, through their knowledge they have an authority over bodily knowledge. Medical authorities produce and maintain ideas of how a normal, healthy body looks, sounds, and otherwise behaves. Thus, they also produce and maintain the ideas of illness

and the sick body as a deviation from the norm. As authors Rinaldi, Rice, and Friedman (2019) wrote, “Fat is made legible via diagnostic tools of measurement, particularly the Body Mass Index, which determines whether and to what extent a patient has a health problem” (6). In this way, they are agents of social control and use their “fine sensibilities,” including medical equipment, tools, and indices, to make the fat body diseased (Murray 2008; Pollack 2013) and justify their own anti-fat bias.

According to Foucault, both material and intellectual conditions create the capability for analyzing the body through this gaze. This capability is not neutral, though. As Fredrik Svenaeus wrote in his 2000 book *The Hermeneutics of Medicine and the Phenomenology of Health: Steps Towards a Philosophy of Medical Practice*, these encounters with medical professionals do “...not take place in a context-free clinical setting separated from the rest of society, but [as] part of its social reality and its structure” (Svenaeus 2000). In other words, medical authorities and their field of knowledge are situated among social norms, dominant ideologies, and biased self-interests. Yet, all of this is made covert under the guise of unbiased objectivity. The assumed reality of medical objectivity is, as Murray claims, a cultural fiction (2008). Instead, the medical gaze is continuously influenced by and reproduces normative methods of existing, understanding, and perceiving. In sum, U.S. society's attitudes and values impact medical authorities in the same way they do the general public. Ultimately, medical professionals are subjects, themselves, of the medical discipline where they are both the possessors of knowledge and reproducers of the ideal. Whether intentional or unconscious, the medical gaze reproduces hegemonic ideologies about the healthy and appropriate body (Murray 2008).

Because of the impossibility of medical objectivity and the infiltration of fatphobia in clinical settings, it is likely that a fat person will be met with anti-fat bias and inadequate

treatment plans (Aldrich and Hackley 2010; Forhan and Salas 2013; Phelan et al. 2015). An example for this, and one I will bring up in the following paragraphs, involves professor and researcher Sonia Meerai. In a doctor appointment involving Meerai's recently heightened blood pressure, her doctor encouraged weight loss as treatment. After Meerai explained some of the social stressors that were more likely contributing to her blood pressure, such as wedding planning, her doctor quickly moved to discussing the social benefits of losing weight, including how Meerai would look at the wedding. If medical objectivity existed, Meerai would not have been given social reasons for engaging in weight loss (Meerai 2019).

It is pertinent to note that fat people are often left out of health care research, aside from specific research on corpulence. Thus, there is an overall lack of evidence-based health care treatment that considers the needs of fat patients. This lack of research and inadequate treatment leads to tangible results for fat patients. For example, fat women are less likely to receive cervical cancer screenings (Cohen, Signorello, Gammon, and Blot 2007) and breast cancer screenings (Mitchell, Padwal, Chuck, and Klarenbach 2008) than non-fat women. Therefore, fat women with breast or cervical cancers are more likely to die than non-fat women with these same cancers (Aldrich and Hackley 2010). This likelihood increases as the patient's weight increases. The heavier the patient is, the more likely it is they will receive inadequate care (Ferrante et al. 2010; Hebl and Xu 2001) and intentional weight loss advice (Halbert et al. 2017). Health care providers often pair this advice with sentiments of disgust and blame (Vartanian 2010), leading patients to feel humiliated, frustrated, and defeated (Alegria Drury and Louis 2002; Meerai 2019; Murray 2008).

Ferrante and colleagues (2010) argue that health care providers tend to believe that fat patients do not care about their health and are less interested in following medical instructions.

Because of this assumption, health care workers may view fat patients as less worthy of adequate care (Ferrante et al. 2010). Doctors have reported preferring not to provide care to fat patients (Persky and Eccleston 2011). One study of primary care providers found that providers spend 20-30% less time with fat patients than non-fat patients (Hebl and Xu 2001: 1249). Medical authorities have reported finding their meetings with fat patients a waste of time (Hebl and Xu 2001; Bleich, Pickett-Blakely, & Cooper 2011). In short, fat patients have already lost the respect of their physicians (Huizinga, Cooper, Bleich, Clark, and Beach 2009) before the appointment even gets started.

Health care providers tend to have less knowledge about fat patient care and support (Brown, Stride, Pasarou, Brewins, and Thompson 2007). What is meant here is that medical personnel tend to over-attribute medical issues and symptoms to merely being fat without referring to diagnostic testing (Malterud and Ulriksen 2011; Phelan et al. 2015). Too often assumptions guide treatment plans rather than investigating any actual medical problems. These assumptions are learned even before a health care provider gains the capacity to practice. In a study on medical students and virtual patient care, patients with shortness of breath were more likely to receive recommendations on lifestyle changes and management if they were considered overweight (54%) than if they were of expected weight (13%) (Persky and Eccleston 2011). As Foucault (2003 [1963]) suggests, doctors merely rely on their own gaze to diagnose and treat a person as obese (Bąk-Sosnowska and Skrzypulec-Plinta 2016).

Health care professionals who consistently demonstrate ethical practices are less likely to intentionally discriminate against their patients (Phelan et al. 2015). However, just because the intent to cause harm is not there does not negate the possibility of unintentional harm. For fat patients, and many other marginalized groups, health care providers tend to impose behaviors

that make patients feel disrespected, unheard, and unwelcome (Meerai 2019; Murray 2008). For example, and mentioned earlier, an essay written by Sonia Meerai's details the intersection of weight and race as treated in Western health care spaces. Near the beginning of the essay, Meerai narrates her experience of planning a wedding, shopping for a dress, and attending a doctor's visit to discuss her health status as "too tall, too big, too wide, too brown, too fat" (2019: 91) person. One of the many significant passages of this essay is this:

When I enter my doctor's office my body is further criticized, except the criticism comes with a much more powerful force than the shop owner's words. It comes with numbers which convey fear — fear that being in a racialized fat body is dangerous for me. The doctor says, "Your blood pressure is too high," I say, "I'm planning a wedding, dealing with a multitude of family dynamics, and working full-time. I'm pretty sure the reason for the rise in my blood pressure is due to environmental factors." The doctor pauses, "Oh...you're getting married? Do you plan on having children?" I reply, "Yes, I do." "Your blood pressure is too high; you need to lose weight. Plus, don't you want to lose some weight for your wedding? You will look beautiful in your dress." I'm in disbelief. Is the doctor telling me that my blood pressure is too high and that I need to lose weight for the purpose of lowering my blood pressure, or is the doctor interweaving the rationale for losing weight with the aesthetic of my body for the wedding? The end result is that I feel fat. Fashion makes me feel fat. Health "care" makes me feel fat. The materialized reality that was constructed for me by the shop owner and doctor is one in which fat signifies danger, risk, ill health, ugliness, and despair. (2019: 91).

What we see happening in this narrative is Meerai is providing her doctor with some of the psycho-social (non-biomedical) factors that are more likely than not contributing to her blood pressure. However, the doctor, using her objectifying medical gaze, is only focused on her weight (biomedical data). Meerai's doctor is focused on providing motivation for intentional weight loss. This advice is seemingly unwanted and increasingly inappropriate as the doctor begins pointing to social reasons, such as wanting to look beautiful in her wedding dress, for reasons to lose weight. The doctor appears to be less concerned with Meerai's genuine health status and more interested in relieving her of the social stigma ascribed to the fat body (2019). As

I discuss later, negative experiences between anti-fat health care providers and fat patients can be, and often are, stigmatizing (Phelan et al. 2015).

Fat Stigma

Stigma has been a popular subject of study in sociology for decades. Though many have written about social stigmas, the most groundbreaking work comes from scholar Erving Goffman. Goffman published his classic book *Stigma: Notes on the Management of Spoiled Identity* in 1963. Goffman explains how stigma is not an inherent part of any person or group of people. Instead, stigma emerges in relationships and social interactions among those who are stigmatized and those who are not. Then, individuals are made to be responsible for their stigmatized identities (Goffman 1963). In this theory, stigmas are known to be characteristics, behaviors, or reputations that are socially discrediting. Individuals become classified as undesirable and are therefore socially rejected. Goffman specifically says, "By definition, the person with a stigma is not quite human. On this assumption, we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances" (1963:5). Thus, stigmatization reduces an individual from a whole, credited person to one who is spoiled (Goffman 1963).

Goffman created a typology of stigma that included three primary categorizations. First, there are the bodily stigmas. These are attributes or qualities that present on the body. For example, fat people's bodies are hypervisible. This constant detectability of our bodies contributes to our stigmatization (LeBesco 2011; Murray 2005, 2008; Saguy and Ward 2011). Second, there are character stigmas. These are the "weak will, domineering or unnatural passions, treacherous and rigid beliefs" (Goffman 1963: 4) that can blemish one's character. Goffman gives addiction, alcoholism, and homosexuality as examples of this stigma. There is

also room for the argument that fatness is a character stigma. Because of the pathologizing, fear, and loathing of the fat body, fat people are viewed as gluttonous, irresponsible, lazy, and unable to control our urges, (Farrell 2011). Though these things are assumed at the sight of a fat body (bodily stigma), they are all descriptions of character flaws (character stigma) (Farrell 2011; Pausé 2012).

Lastly, there is community stigma. These qualities are met through affiliation with race, nation, or religious groups. Goffman said this stigma “can be transmitted through lineages and equally contaminate all members of a family” (1963: 4). Fatness serves as a symbolic marker of an individual’s lack of social status. As Snow and Anderson write, "symbolic expressions of social power often reproduce stratification in ways that diminish individuals' potential participation in actions that bear directly on their material well-being" (2001: 397). There can be no denial that fat people's life chances are reduced due to the cultural stigma attached to their bodies (Farrell 2011). Therefore, as a group, fat people are continuously faced with social inequalities such as fewer job opportunities, exclusion from activities, and less medical support outside of weight loss programs. Consequently, we must acknowledge fatness as bodily, character, and community stigma (Farrell 2011).

Goffman’s stigma theory addresses stigma both categorically and experientially. Thus, while he has outlined these three primary forms of stigma mentioned above, he also describes stigma as discredited (visible) or discreditable (cancelable) (Goffman 1963). Goffman describes how a discredited identity is one that is visibly spoiled. This is that the attribute(s) that are stigmatized are evident in nearly all social situations. Whereas a discreditable identity is one where these attributes are not immediately apparent. Aside from anonymous online spaces, the fat body is hypervisible in social settings. Therefore, fat people exist in a world where the

stigmatization we feel is found at these three levels of bodily, character, and community, in addition to having discredited identities.

Though Goffman emphasizes the social construction of these stigmatizing attributes, in the sense that they are not inherently stigmatizing and instead are given stigmatized meanings by a group, this cannot take away from material reality the stigmatization causes for those with spoiled identities. The essence of stigma is to invoke a division between groups and individuals based on negative stereotyping. This division sets up a social categorization process in the form of hierarchy where some identities are considered dominant and others inferior. Though Goffman's work continues to be considered groundbreaking on this topic, other theorists have reimagined his work. For example, Falk (2001) offers a comprehensive review of stigma as it is constructed and experienced in the U.S. in *Stigma: How We Treat Outsiders*. He writes, "stigma and stigmatization is everywhere because almost any conduct or any characteristic can be seen as deviant by some audience" (Falk 2001: 24). He describes the fluidity of stigma, in that at one moment, something stigmatized may not be later in certain times or locations. What is unique about his perspective is his conceptualization of the Americanized stigma. He argues:

The root of stigmatization in America lies in the perceived or assumed discrepancy between that core value and the perceived deviation from that norm. Stigmas in twenty-first-century America are produced by the inability of many of us to live in conformity with the publicly proclaimed norms taught in our schools, through our media, and in informal communication. Hence, members of stigmatized groups are seen as violating traditional American values (Falk 2001: 333-334).

Using this Americanized understanding of stigma, we can view fat people as having violated the healthy American body norm and, therefore, the healthy American citizen trope (Falk 2001; LeBesco 2011). Though there are many ways to research and analyze fatness, stigma theory gives a sense of theoretical validity to fat people's discriminatory experiences. Furthermore, this

theoretical perspective also provides explanation as to the social responsibility, at both micro and macro levels, imposed upon fat people for merely living within a fat body (Farrell 2011).

Fat stigma has its own history and cultural context within the U.S. (see: Farrell 2011; Strings: 2019). Historical events and oppressive systems such as colonization and anti-Black racism (Strings 2019), entertainment (Himes and Thompson 2007), fashion (Cooper 2016), activism (Cooper 2016), and public health (LeBesco 2011; Oliver 2006; Gordon 2020; Tovar 2018) have all contributed to the social understanding of the fat body in the U.S. Farrell wrote, "Fat was neither neutral nor insignificant, but was a central protagonist in the cultural development of what constituted a proper American body" (2011: 5). Elliott (2007: 134) also explains that "the figurative concept of citizen 'fitness' is often mistakenly conflated with the visible look of leanness." Thus active, working, thin bodies who manage their health, well-being, and success on their own are deemed the "good" citizens who contribute to societal progress and democracy (Elliott 2007; LeBesco 2011). In opposition, those in fat bodies are failed and irresponsible citizens (Pausé 2014; 2017) who damage social progress (Elliot 2007; LeBesco 2011).

LeBesco (2011) asserts that there has been a shift to a neoliberal form of governmentality that has convinced most of the U.S. population that fat bodies are draining health care because of bad personal consumption and lifestyle choices. We see this reflected in legislation (LeBesco 2011) and anti-fat public health campaigns (Gordon 2020; Tovar 2018). According to Petersen (2003: 194), "Citizens are increasingly expected, as a condition of access to health care services, to play their role in minimizing their contribution to health care costs by becoming more responsible health care 'consumers,' and adopting appropriate practices of prevention." Thus, public health strategies are primarily focused on "the behavior and appearance of individual

bodies” (LeBesco 2011: 154). Individual citizens have been *responsibilized* (Rous and Hunt 2004) and mobilized (LeBesco 2011) to police their own and others’ bodies.

Not only does this speak to Goffman’s conceptualization of stigma, but this idea touches on some of Foucault’s theoretical contributions as well. Foucault (1975) has marked the way we tend to normalize certain kinds of bodies, which he calls docile bodies. Much of the population, those with docile bodies and those without, have been led to support the normalization of these bodies. More than this, individuals are encouraged to police deviance in order to prioritize the docile body type. In this thinking, the fat body is deviant. The expectation for navigating this stigma becomes admitting to this deviance and seeking the appropriate bodily discipline (Foucault 1975). Hence, we see the dehumanization of fat people as they are viewed as works-in-progress at best and a drain on society at worst.

Fatphobia, as an oppressive and stigmatizing system, is not singly tied to notions of citizenship. It is erroneous to consider this oppression as a single-layered issue. Because the body is gendered, raced, and classed, among other social categorizations, fatphobia is inherently connected to other forms of social oppression. Farrell wrote, "Fatness was a motif used to identify ‘inferior bodies’—those of immigrants, former slaves, and women—and it became a telltale sign of a ‘superior’ person falling from grace” (2011: 7). Farrell is not alone in recognizing these historical and identity-based developments in association with fatness. In *Fearing the Black Body*, Strings (2019) develops an historical narrative that underscores how fatphobia is linked to the notion of racialized inferiority. Her work unveils how fatness is used as a stigma tool to validate ideas about superiority in race, class, and gender (Strings 2019). Similarly, Abigail Saguy has discussed how the framing of fatness as a deadly, threatening epidemic is used to defend “imposing elite white preferences for thinness onto working classes

and people of color” (2013:27). Other scholars have connected the activism around fatness to that of the LGBTQ community (Cooper 2016; Hagen 2019; Pausé 2012; Saguy and Ward 2011; Tovar 2018). In fact, much of the more radicalized fat activism was spurred by fat, Black, Jewish, lesbians (Cooper 2016; Hagen 2019; Tovar 2018).

Managing Stigma & Coping

Stigmas can be hindrances to one’s social acceptance. Thus, as Goffman (1963) theorized, individuals use stigma management strategies to hide or reduce the presentation of the stigmatized self. In essence, these strategies are coping techniques for living with “spoiled” identities (Goffman 1963). There are various strategies that stigmatized individuals have used such as covering, where a discredited stigmatized person tries to downplay their stigmatized attributes, or passing, where a discreditable stigmatized person attempts to assimilate into or remain assimilated in the non-stigmatized population (Goffman 1963). Individuals have also engaged in education or explanation, where individuals will choose to educate others on their stigmatized identities. Additionally, some people will withdraw from or avoid social interactions altogether. While these strategies are employed to either deter or soften any negative judgement or responses, each strategy comes with its own potential drawbacks. For example, covering and passing can increase tension within oneself, relationships, and social interactions; explaining comes with the risk of further stigmatization; and withdrawing or avoidance keeps individuals outside of opportunities and institutions (Goffman 1963; Winnick and Bodkin 2008).

Stigma management has been studied in a variety of different populations such as those with HIV/AIDS (Poindexter and Shippy 2010; Siegel, Lune, and Meyer 1998), homeless individuals (Roschelle and Kaufman 2004; Snow and Anderson 1987), lesbian and bisexual women (Hylton 2006), ex-convicts (Winnick and Bodkin 2008), physically disabled people

(Taub, McLorg, and Fanflik 2004), and those with mental illnesses (Elliott and Doane 2015). Empirical studies and theoretical articles have consistently demonstrated that stigma management responses are inconsistent and may alter due to the condition in which the stigma is confronted (van Amsterdam and van Eck 2019; Anderson and Snow 2001). Humans are creative in the ways that they engage their stigmatized identities in the social world and attempt to restore a positive sense of self (Anderson and Snow 2001; Goffman 1963). While many individuals engage in stigma management to protect their sense of self and maintain a level of social acceptance, this is not always the outcome. For example, some individuals have been found to engage in “defensive othering,” where a stigmatized individual verbally demoralizes a fellow stigmatized individual in their group or a different one (van Amsterdam and van Eck 2018; Roschelle and Kaufman 2004). An unintended consequence of this management strategy is the reinforcement of negative stereotypes about their own stigma, therefore aiding in their continued discrimination and marginalization (Yasuike 2019). As Goffman's (1963) original work outlined, there are several ways that people with stigmatized identities may resist any negativity associated with their identity and there are many outcomes to these tactics.

Fat stigma dissuades fat patients from accessing health care (Alegria Drury and Louis 2002; Barlösius and Philipps 2015; Lewis et al. 2011). Researchers Alegria Drury and Louis (2002) conducted a study to explore fat stigma and its impact on health care participation. After analyzing survey responses from 216 women in the Las Vegas area, these researchers found that the higher the BMI of a participant, the greater the delay or avoidance of health care. In addition to this, the participants listed 19 reasons for health care avoidance. These included having "gained weight since last health care visit," not wanting to "get weighed on the provider's scale," and knowing they would be told to "lose weight," to name a few (Alegria Drury and Louis

2002). To navigate this world with a “spoiled identity” (Goffman 1963), these women chose to withdraw, a stigma management strategy, from the health care process altogether.

Although there is little research on stigma management in health care spaces, there is some research on fat stigma management in other settings. Researchers van Amsterdam and van Eck (2019) reviewed the different stigma management strategies used by fat women employees. Their overall findings demonstrate that there is not one specific strategy for managing stigma. Instead, stigma management in the workplace is more complicated than a single action. They found that the women’s reactions to weight-related stigma were fluid and adjusted to the situation, who they were interacting with, and the general mood felt within the environment. Some of the strategies the research participants described implementing reproduced dominant notions about being fat. These including things like hiding, humor, and compensating. For example, one of the study participants explained how she felt compelled to use humor to compensate for her fatness (van Amsterdam and van Eck 2019). She said:

I feel like I have to be a more enjoyable person than others and funnier. Sometimes I mock myself, only to prevent others from doing that. It is better to make the jokes myself because then it is less hurtful. People always say I’m funny. And yes, I believe I use humour to compensate for being fat (van Amsterdam and van Eck 2019:52).

These researchers also found these women used strategies that sometimes challenged the dominant understandings of fatness. These included things like flaunting themselves, the use of irony, rebellion and demonstrating self-acceptance. For example, a different participant describes her rebellious nature as a fat woman when she said:

I try not to hide myself in clothes but stand out by painting my hair red and wearing cupcake dresses. It is a little rebellious. I just think: you want to look at my fiery red hair or dress with cupcakes on it? And then what, what do you want to say? A fat woman in a cupcake dress? SO WHAT! (van Amsterdam and van Eck 2019:51).

Rebellion and resistance to fat stigma seem to be common forms of stigma management for fat activists (Saguy and Ward 2011). Abigail Saguy and Anna Ward conducted research on just this. Specifically, their work involved fat activists and the coming-out narrative as a tool for stigma rejection. Because fatness is more than visible on one's body, "coming out" does not refer to some act of informing the world about one's size. Instead, "coming out" refers to the reclamation of the word "fat" and of one's own acceptance of their fat body. Many fat people have found comfort and empowerment from coming out as fat. For example, Saguy and Ward (2011) interviewed prominent fat rights activist, zine producer, and author Marilyn Wann about coming out as fat. She said after a love interest expressed his embarrassment of her weight, Wann realized that "living in the closet [was] not working," and she "decided to come out as a fat person and tried to do it really publicly and really loudly because . . . [she] wasn't going to put up with exclusion" (Saguy and Ward 2011:53). Others, however, question the utility of this narrative. Murray (2005) argues that due to the fat body's hypervisible nature, the coming-out narrative seems useless at best and encourages the hegemonic performance of thin ideals at worst. In this, Murray (2005) insinuates that fat resistance in the form of fashion shows and pool parties are methods of trying to mimic the thin world. Ultimately, Saguy and Ward (2011) contend that fat activists are innovative in their use of this narrative to affirm their visible stigmatized identities. Through interviews with fat activists, the authors conclude that while fatness is a visible identity, there is still a transition from merely being a fat person to coming out as a fat person (Moon and Sedgwick 2001; Saguy and Ward 2011). This process of unapologetic acknowledgment of being a fat person is a way "of making clear to the people around one that their cultural meanings will be, and will be heard as, assaultive and diminishing to the degree that they are not fat-affirmative" (Moon and Sedgwick 2001:206).

Although the strategies mentioned so far may have been useful to those enacting them, one study found the most common response to stigma was no response at all (Lewis et al. 2011). This study, conducted in Australia, explored the way fat people responded to direct, indirect, and structural stigmatization. Of the 142 participants the researchers had in their study, 121 described having experienced stigmatizing attitudes and behaviors throughout their lives, primarily in social settings. Interestingly, those who did not describe experiencing any stigmatization acts had some of the lowest BMI levels or were men. Over half of the participants reported experiencing direct experiences of stigma. Like their conversations with health care providers, participants mentioned how friends and family members would subtly dehumanize them in conversations. For example, instead of talking with them, family and friends would talk around these fat people, as if to question their capacity to act, interact, and/or participate in society. If the conversation did directly involve these fat individuals, it would be so these friends and family members could push unsolicited diet advice onto them. Under half of the participants mentioned feeling stigmatized via environmental cues such as lack of properly sized equipment and seating, lack of clothing options, and lack of positive media representation. Most of the participants had experienced indirect stigma. This included others' behaviors like stares while eating or judgmental mannerisms or statements. This also included their own feelings of damaged social credibility of being 'the fat friend' and the feelings of personal responsibility for their weight. Overall, most participants felt like anti-fat attitudes and rhetoric were unavoidable. Not responding was the most common (in)action these individuals took to manage these acts of discrimination and prejudice. When it was mentioned that a response was made, it was mostly an internalized rationalization of deservedness (Lewis et al. 2011). In other words, the participants would recognize and accept why they might deserve to experience any sort of prejudice.

Fat people generally feel uncomfortable, stigmatized, alienated, and unheard in medical encounters (Alegria Drury and Louis 2002; Meerai 2019; Murray 2008). Much of this has to do with fat patients being given less time with medical care providers (Hebl and Xu 2001), not being respected (Huizinga et al. 2009), and rarely being provided appropriate health care (Phelan et al. 2015). This seems to be the extent of our scholarly knowledge at the intersections of fat, medicine, and health care visits. Therefore, this research will fill in the literature gaps by providing insight into how fat patients perceive their interactions within health care settings and with health care employees.

CHAPTER III: RESEARCH METHODS

There is very little research on anti-fat bias in health care spaces or on fat patients' experiences. Of the research that exists, much of it is comprised of quantitative surveys and is rooted in anti-fat rhetoric itself. Thus, there is a need for qualitative work on this subject in order to uncover rich, new insights into the perpetuation of stigma in these assumed objective locations. Qualitative research methods encourage deep immersion into the data collection and analysis process. Though other methods may offer some basic understanding into fat patients' experiences in medical encounters, in the words of Clive Seale, "If you want to find out about something you should go and ask some people about their experience of it" (Seale 2004: 253).

Moreover, qualitative methods offer something quantitative methods rarely does — human connection. As highlighted in the literature review section, dehumanization is a common experience for the average fat person in the U.S. While quantitative methods are not inherently dehumanizing, qualitative methods, like in-depth interviewing, tend to offer eye-to-eye or voice-to-voice connection. Qualitative methods offer the capacity to review the complexities of social dynamics, identities, and interactions. In essence, qualitative research gets at the meaning associated with people's thoughts and actions.

As a sociological researcher and fellow fat person, I am interested in knowing the experiences of fat people in the U.S. who are navigating the U.S. health care system. This includes understanding any preparation for appointments or visits, fat peoples' experiences in exam rooms and waiting spaces, advocacy, and stigma management strategies, and what they felt post-appointment. Through qualitative methods, I collected in-depth, complex, and rich information on this subject.

Research Design

This study is based on semi-structured, in-depth interviews with fat women that addressed their positive, negative, and sometimes ambiguous health-related experiences. Sampling methods consisted of purposive sampling using Facebook and Instagram as recruitment sites. Of the individuals who had responded, 15 women scheduled and completed interviews with me. Due to the COVID-19 pandemic, all interviews were conducted remotely via Webex video conferencing or a phone call. All interviews lasted between forty-five and ninety-minutes. All data were analyzed using an open, thematic coding process. This analyzation process was chosen to allow for the major themes and sub-categories to emerge on their own. I received approval from Western Michigan University's HSIRB in February of 2021 (See Appendix D) for this research study.

Recruitment & Sampling

Sampling methods for gathering research participants consisted of purposive sampling in online settings. Purposive sampling is used to access specific populations that may not be easily accessed with more non-probability sampling techniques (Babbie 2011). This sampling method lends researchers more control over getting connected with their study's population (Barbour 2001). I chose this sampling method because of my research-based desire to specifically connect with fat folks across the U.S.

I set out to interview 10-20 self-identified fat individuals about their experiences with U.S. health care and health-related experiences. I made the intentional choice to not request information on weight, BMI, clothing size, or other proofs of fatness. Though some participants showed immense willingness to provide this information, the collection of this information did not appear to add further value to this written work. In essence, the negative consequences of

collecting this information felt much larger than the potential benefits. If participants offered this information, it was not denied. In total, I interviewed 15 fat women. Eligible research participants included fat people in the U.S. of any gender, race, or class status who were 18 years old or older. I set out with the intention of honoring the complex and diverse experiences of fat people. Thus, there were few restrictions placed upon the participant pool so to have this research open to the expansive experiences of the various fat citizens of the U.S.

Potential participants were recruited via online social media posts in fat-specific Facebook groups and on my personal Instagram account and with the use of strategic fat-specific hashtags. These hashtags included #fatacceptance #fatstigma #weightstigma #bodyliberation #medicalbias #fatresearcher #fatresearch. The posts were both an image of and a text description of the HSIRB approved call for participation for this research. This call for participation included information about this research, the requirements for eligibility, and how to get in contact with me. For the Instagram post, I also included two images of myself. This was for two reasons. First, Instagram is an app that is primarily used for posting photos and captions. Thus, it felt appropriate to attach a set of photos. Second, I thought this could encourage any potential participants to reach out because they'd see that this research was being done by a fellow fat person.

There were no consent procedures to navigate for posting on Instagram because I chose to only post on my personal Instagram account. After posting, I had friends, colleagues, and other fellow fat Instagram users repost the call for participation on their own Instagram stories out of solidarity. None of that marketing was requested, but I delightfully accepted this support. For Facebook groups, there tend to be administrators and moderators for online groups. I

requested explicit permission from the admins and moderators before posting the call to action. If I did not gain permission, I did not post the message.

Recruitment for this research was an invigorating process. I posted the call for participation (See Appendix A) in three places. Once on my personal Instagram, once in a general fat-specific Facebook group, and once in a topical fat Facebook group. Though I am a Facebook member of both groups, these were not groups that I actively post in. These posts stayed up un-edited for two days. By the third day, I had to quash my call for participation due to the level of interested potential participants. Some individuals emailed me right away and others made comments on the post indicating interest in participation. If individuals only made comments and did not send an email, I replied to their comment encouraging each person to send me an email. Unfortunately, I did have to face the unfortunate reality that interest in research does not mean commitment to participation in said research. Some individuals who reached out, all of whom received a response from me, never responded. This happened six times throughout the recruitment process. This left me with fifteen individuals interviewed.

Once I received an email requesting further information about participating in this study, I replied with a standardized response thanking them for their interest, attaching the study's informed consent form, and requesting that they consult with my digital calendar to schedule a time to meet remotely and indicate their preferred method of communication. As soon as I received the meeting notice, I sent a follow-up email confirming the day, time, and method of communication. I also reminded the interested participants to review the consent form before our scheduled meeting. I also sent a reminder email to all interested participants within 12-24 hours of our scheduled meeting.

I began each meeting by reading the consent form out loud to the interested participants. The informed consent document sent to the participants and read aloud was approved by Western Michigan University's HSIRB (See Appendix B). I then gave the participants time to ask questions about the study. Then I asked the participant to confirm or deny their participation in the study.

Interviews

Data collection via semi-structured, in-depth interviews proved to be fruitful for unveiling the details and stories of fat people in health care settings. To find a balance between freedom and structure, I prepared a list of interview questions (See Appendix C). This list was modified as needed throughout the interview process to honor the demands of this research and the direction that the participant wanted to take the interview. I had a specific goal of keeping the interview conversational instead of formal and rigid to create a welcoming environment for the participants to tell their stories at their own leisure. In creating this environment, I gave interviewees the opportunity to bring up topics that may have been unintentionally excluded from the interview guide. For example, I did not have questions about fatness as it intersects with parenthood. Nevertheless, many research participants happened to be parents and described how parenthood altered the way they interact with bodies and health.

As mentioned above, the COVID-19 pandemic was occurring at the time of data collection and analysis. Thus, all interviews were conducted remotely via a Webex video call or a phone call. Research participants had the ability to choose which method of communication honored their schedule and comfort best. Very few participants chose the phone call option. For the video calls, participants were encouraged to make their own decision about if they wanted their camera on or off. Only one participant chose to have her camera off and this was due to

internet connection issues. All interviews were video recorded and transcribed. Webex provides a transcription to all digitally saved recordings. Upon download and completed editing of each interview's transcription, the raw video of the recording was permanently deleted. All transcriptions were edited to show which statements were my own and which were made by the research participants. Additionally, the transcriptions were edited to remove any autocorrect mistakes and any identifying details. These details included things like hometowns, health care staff names, and specific hospitals or clinics where appointments were held.

Interview Process

All interviews, whether conducted via video or phone call, were conducted in a spare room in my own home. This room was chosen because it has a lockable door. Utilizing this room allowed for extra privacy as my partner and I were both working from home due to COVID-19 at the time of this data collection. All interviews were recorded with the use of Webex. If the interview was over the phone, I still used Webex as a way of recording the interview.

All interviews were semi-structured in nature. I took my own notes throughout every interview to help me concentrate on the interviewee's comments and stories, and so I might have a chance at addressing any strong, personal emotions or reactions that came up during the interviews. The interview began with a short socio-demographics survey (See Appendix C). Following these questions, I asked my participants broad questions about the treatment of fat people in the U.S. and their individual meanings of the word fat. This portion of the interview gave me insight into how these individuals viewed the world around them, connected to their bodies and defined health for themselves. Following this came questions about health-related appointments, visits, and encounters. Here we got into the details of their treatment as a fat person seeking health care in the U.S. This included requesting information about both positive

and negative health care encounters. I also probed about self-advocacy and the ways these individuals responded to health care-facilitated stigmatization. We also explored what occurred for these participants post-appointment. The final section requested information about sharing these experiences with others and what they wish the medical industry would do differently. The final question requested any closing remarks from the participants and if there was a chance for follow-up as needed.

For most of these interviews, I followed to the interview guide, adjusting as needed. Examples of when I needed to adjust the guide included when participants would unintentionally answer a question I was planning to ask later in the interview, if we ran out of time, or if the research participant took the interview in a direction I did not expect.

Interview Analysis

Throughout my data analysis process, I was loosely guided by the principles of grounded theory (Charmaz 2006). I initially chose grounded theory to guide this work because of the way this theoretical framework leaves space for patterns to emerge from the data. This is in opposition to holding any theoretical or practical expectations so that I could “remain open to exploring whatever theoretical possibilities can be discerned in the data” (Charmaz 2006:47).

In the beginning, I planned to edit and conduct at least one read through of each transcription individually before moving onto my next interview and beginning the process over again. However, this did not occur due to how closely interviews were scheduled, sometimes having up to three interviews a day, in order to make participation in research convenient for my participants. Thus, after the first two interviews, I made the decision to complete all transcriptions after the completion of all 15 interviews. Because this does not follow the typical grounded theory process, I can only claim that my methods were *loosely* guided by grounded

theory. Although I felt compelled to choose this direction for my transcription and coding process, this does not mean I was not still altering my process and ideas of this research as these interviews progressed. For example, some of my research participants were emphatic about their community, including partners, siblings, and parents, being part of any processing before or after appointments. Thus, I began asking more pointed questions about my researchers involving other people in their health care appointments.

Once having downloaded the raw transcripts, which were produced automatically by Webex, I completely edited each document line by line. This included adjusting any misspelled words that were created by the transcript and making clear the difference between my statements and questions, and those of the research participants. Amid this editing process, I also engaged in a memo-writing process through both the interview and analysis process (Charmaz 2006). Memo-writing is not merely a part of grounded theory principles but is overall valuable to any qualitative researchers coding process. Memo-writing assisted me in addressing my own biases, assumptions, and general reactions to the stories I captured.

After I completed my transcription edits, I conducted a full read-through of each document. In this read-through, I would both highlight statements that stuck out to me and leave myself comments in the word document. After the first reading of each document, I reviewed these highlighted statements and all the comments I left for myself. While reviewing these comments, I continued to write memos where I would question the direction of the data, process my own comments, and express any emotions I had about reading the transcriptions and my own notes.

Once I completed an initial read through and completed my memo writing, I then moved onto my second readthrough. Here I engaged in more critical analysis as I looked for common

topics, experiences, and statements made by my participants. Ultimately, I was attempting to thematically categorize the data before me. This led me to developing a list of reoccurring topics and categories. For example, I started off with a broad category of “health-related experiences/ appointments/ visits/ etc.” From there, I quickly separated these experiences into “Good appointment,” “Bad appointment,” and “General comments about appointments.” Though these categories simplify the complexity of these stories and experiences, this was a necessary step for the coding process. Following this categorization process, I reviewed the participant responses that evidenced these categories for any other categorizations, patterns, and themes. I paid special attention to physical sensations, emotional sensations, and patterns of health care employee comments and overall treatment. This process helped me in reducing the data and uncovering major themes of the interviews (Emerson, Fretz, and Shaw 2011; Saldana 2008).

CHAPTER IV: THE CONTEXT OF FATNESS AND HEALTH STATUS

In this section I describe my research participants, including their socio-demographic information, and their perspectives on fatness and health. They informed me on what it means to be fat, what the social treatment of fat women, particularly White fat women, is like in the U.S., and how they conceptualize health status. This section aids in providing context to the experiences of U.S. fat women. Furthermore, the stories and experiences described in this section are aspects of their lives that inform how they feel within health care settings.

Participant Descriptions

I interviewed 15 women for this study. None of them mentioned identifying as transgender women, and four of them specified that they were cisgender women. The majority of participants were recruited via the Facebook group postings mentioned in the methods section. Only one participant mentioned seeing the Instagram post on my personal account. Geographic data was not collected via the socio-demographic survey, but at least five participants were in different time zones from myself. Most of these individuals, at least at the time of the interviews, were residing somewhere in the Midwest. Their ages ranged from 23-53 with a mean average of 35-years-old.

The educational levels of my participants ranged from associate degrees to PhDs. Two participants held an associate degree. Six participants had their bachelor's or a four-year undergraduate degree (equivalent to a Bachelor's). Five participants held a master's degree. Two participants earned their PhD. Though I did not collect specific information about their academic pursuits, some of the fields of study mentioned included sociology, psychology, anthropology, and English. Unfortunately, this study did not capture the experiences and stories of those who have not participated in or formally completed any tertiary education.

The majority of this study's participants identified as White. One participant identified as a Multiracial Black woman. Another participant identified as Black and/or African American woman. All other participants identified as White. Though I had aimed to gather a more diverse cohort for this research study, this outcome is unsurprising. Much of the current research on fat people does not have diverse sampling pools. Addressed later in this written work, there are multiple compounding limitations that contributed to the overall lack of a diverse group of interviewees. To be clear, the experiences of participants Layla and Lynn, who identify as a multiracial Black woman and a Black and/or African American woman respectively, are highlighted in this study. Furthermore, their perspectives provide rich insight into not only the intersections of Blackness, fatness, and womanhood, but the addition of being diagnosed with polycystic ovarian syndrome. However, in heeding the direct scholarly advice of author and professor E-K Daufin (2019), I must make it explicitly clear that because this study includes mostly White voices, it is primarily about fat middle-class, White women's health care experiences.

The primary criterion of this research was to be a fat person in the U.S. Thus, each of the participants self-identified as fat. They were also asked if they identified with other body-based terms or categorized their body as anything other than "fat." Some of the more common body-based terms included "plus sized," "chubby," and "big/bigger body." A few outliers included "obese"⁴, "tall," "small fat," "mid fat," and "superfat." Each participant was also offered the opportunity denote any other identities that they deemed relevant to this research. Many of the individuals did not list any other identities, although some did. Some of the identities that came up included parent status, marital status, sexual orientation, health and diagnosis status,

⁴ This was specifically used as medical terminology.

disability, being a sexual assault survivor, and class status. These are mentioned throughout this written work.

There was quite a bit of overlap in the types of health diagnoses that these women shared with me. It should be noted that I did not explicitly ask for any diagnosis information. Therefore, there may have been other conditions that these women were navigating that either did not come up or that these women did not feel comfortable enough to share. Over half of these women shared with me that they were diagnosed with a mental health disorder such as anxiety or depression. Of these women, five of them had disclosed having a diagnosed eating disorder. Additionally, a quarter of these participants told me they had polycystic ovarian syndrome (PCOS). PCOS refers to a hormonal disorder that often causes a variety of symptoms such as ovarian cysts, excess hair growth, acne, and infertility. According to the American College of Obstetricians and Gynecologists (ACOG), four in five women with PCOS are considered *obese* (ACOG 2020). Only one participant did not share any health diagnosis with me.

All research participants were given the opportunity to choose their own pseudonym. Very few participants chose this for themselves, and so I was often tasked with choosing one for them. All names were chosen at random and with the purpose of maintaining a non-identifiable status within the context of this research. Of the fifteen participants I spoke with, no one requested a follow-up meeting or any follow-up information, nor did I follow-up with questions about the answers they provided during the interviews.

Conceptualizing Fat: Finding Meaning in a Large Body

To repeat, each of the individuals interviewed for this research self-reported as a fat person. In fact, the word “fat” was the primary way that each of them used to either identify themselves (ex. “I am fat”) or to describe their bodies (ex. “I have fat”). I did not explicitly

request an explanation of the differences between identifying as fat and describing one's body as fat. However, one participant, a White woman (pseudo)named Caroline, told me, "I'm not an adjective. I have a lot of body fat. So yes, I am a fat person, but to say, 'I am fat,' that's just always kind of been sort of weird." Caroline's comment implies there is some resistance or uncertainty for her with committing to a fat identity.

Most of my research participants were strongly opposed to language such as "obese," "morbidly obese," or "overweight." They explained that language like this perpetuates negative assumptions associated with fatness. The commonality of this explanation from my participants is inextricably connected to my choice in recruiting participants from online, fat-positive groups. Also linked to my research participant recruitment locations, some of the participants also used language like "small fat" and "infinifat" to describe their bodies more precisely. These concepts come from host of *The Fat Lip* podcast, Ash's "The Fatness Spectrum" framework (referenced in Gordon 2020). The framework is this:

Small fat: 1x-2x, sizes 18 and lower, Torrid⁵ 00 to 1. Find clothes that fit at mainstream brands and can shop in many stores.

Mid-fat: 2x-3x, sizes 20-24, Torrid 2 to 3. Shop at some mainstream brands, but mostly dedicated plus brands and online.

Superfat: 4x-5x, sizes 26-32, Torrid 4 to 6. Wear the highest sizes at plus brands. Can often only shop online.

Infinifat: 6x and higher, sizes 34 and higher, some Torrid 6. Very difficult to find anything that fits, even online. Often require custom sizing.

This framework provides the general t-shirt or top size range, pants or bottoms size range, and the Torrid retail clothing store size ranges associated with each label. Additionally, there is a short description about the ease or strain in buying clothing. Ultimately, this framework was developed to provide fat people, particularly women or those who buy clothes in women's sizes,

⁵ Torrid is an American women's retail clothing chain. They primarily sell to "plus size" clothing.

with more accurate terminology to describe our bodies. Even more, it was developed to highlight the difference in experience, particularly clothing access, based on one's size. For example, small fat people tend to experience less violent discrimination and restriction than infat people. As Gordon explained in her latest book *What We Don't Talk About When We Talk About Fat*, "These gradations are frequently used within fat spaces to help pinpoint the privileges we experience by virtue of our relative proximity to thinness" (Gordon 2020:9). In essence, though fat people have a myriad of similar experiences, it is imperative for us to understand that there is no single fat experience.

Some participants also used language like "plus-sized," "chubby," or "bigger." For these participants, there was no common reason for using this language. Additionally, these participants were a minority compared to the participants who were strongly opposed to these euphemisms. One White participant, May said that people, particularly thin or straight-sized people, use phrases like "plus size" or "bigger" when they want to describe someone's body and "they're trying to be nice." May's comment implies is that it is *not nice* to call a fat body, fat. Though it is true that the word "fat" has been used to insult fat people for ages, there has been a call for reclamation, rebellion, and liberation since the early 1970s with the development of Fat Activism (Cooper 2016) and the *Fat Liberation Manifesto* (Freespirit and Aldebaran 1973).

Several women also told me that words like "chubby" or "big girl" were merely euphemisms that they used to make other's more comfortable and were neither accurate nor authentic. For example, Martie, a 26-year-old queer White woman, mentioned only using euphemisms like this in front of her family. Because Martie's family have had members pass away due to reasons they connect to fatness, they have deeply internalized a fear of fat. In some ways, Martie is protecting both herself and her family by choosing language like this. She

protects herself from the reactions her family would have if she were to call herself “fat” in front of them. Common responses include “Don’t call yourself that!” and “You’re not fat! You’re beautiful.” She also protects her family from acknowledging their proximity to fatness. Author, Aubrey Gordon (2020) associates the use of euphemisms to people’s fear of seeing, naming, and potentially existing within a fat body. This fear holds true for both fat and non-fat people. While numerous fat people have reclaimed “fat,” this is not the reality for all.

When asked specifically about what “fat” meant to these individuals and why they use this word, two primary themes came forward. First, to be fat is to live in a body that is larger than the societal standards deemed appropriate or normal. Maddy, a White woman and mom of two children, connected her fatness and use of the word to how White, European rule-governance has influenced values in the U.S. She said, “I think there is a rule that bodies should look a certain way and I think a lot of institutions in our society have been set up around these rules.” Therefore, the mere existence of the fat body inherently breaks these rules. Martie, a participant referenced earlier, also spoke to some of this rule breaking, specifically highlighting the joy it brings to call herself fat. She said, “Anything that deviates from that [bodily expectations] is a threat to our capitalistic society. Not just deviates but, deviates and rejoices in that deviation because I think you need fat bodies in order to normalize thin bodies, but you can’t have *happy* fat bodies.”

Second, fat is neutral. Contrary to the stigmatized social perspective of fatness, many participants plainly stated that the fat body is not inherently negative nor is “fat” a bad word. Heidi, a 35-year-old White woman said, “Fat is a neutral descriptor to talk about the size of the body in which I live.” Lynn, a 25-year-old Black woman, similarly shared, “It’s [fat] what I am...But it doesn’t mean I’m a bad person or anything like that.” In her perspective of fat and

fatness, Lynn removes the moral failure or wrongness from the social definition of fatness. Many participants agreed that fatness is just the reality of their body. For example, White participants Anne and Joy both mentioned that using the word fat to describe their bodies underscored the acceptance of their size and bodily appearance. Another White participant and mom of four, Stacy mentioned that calling herself fat normalized her body for herself and for her children. Ultimately, there is nothing hidden when calling a fat body *fat*.

Negative, Bad, Unacceptable: Being Fat in the U.S.

All but one of my interviewees mentioned being familiar with fat-centered social movements such as Fat Acceptance and Body Liberation. This was not an intentional expectation set for participation in this research. Nevertheless, because almost all research participants were recruited in fat-positive online spaces, it is unsurprising that the majority of participants knew of these social movements. Though specific frameworks used by activists and scholars vary across the U.S. and globe (Cooper 2016; Gordon 2020), the linking components across these frameworks are the critiques of the social treatment of stigmatized bodies, the systemic oppression felt by individuals who exist within those bodies, and the institutions that perpetuate stigmatization and discrimination. Because all my participants are fat women and most have familiarity with the social movements, they demonstrated both individualized and collective understanding of the social treatment of fat people in the U.S. When asked about exactly this, various thoughts and individual experiences came up.

My participants described a paradox of fatness where we, fat people, are both invisible and hypervisible, depending on the social context of any given situation. Writer and Professor, E-K. Daufin also acknowledges this paradox as it is particularly experienced by fat Black women and girls. Daufin said, “Fat Black women suffer from a toxic intersectional combination of

hypervisibility (when one needs someone to blame for a bad outcome) and invisibility (when it comes to inclusion in sharing the good) (2019:161; Mowatt, French, and Malebranche 2013). To be clear, I do not claim that this is same paradox for all fat people. Doing so would violently erase the oppressive and stigmatizing experiences of Black women and girls. My White participants' and my own experiences are completely outside of Daufin's (2019) reference because of the privilege and protection we gain from our Whiteness in a White supremacist society. What I do recognize, though, is that my participants spoke to a similar dichotomy of fatness' hypervisibility and invisibility.

In reference to invisibility, the social perception of one's fatness overshadows other qualities and attributes of fat people, rendering those aspects of ourselves invisible. Specific examples provided by my participants included feeling invisible as intelligent people, as actively sexual beings, and as productive members of society. Several participants described feeling like people tend to assume that fatness and intelligence are mutually exclusive. For example, Stacy, a White therapist who proudly holds her master's degree, feared people's perceptions of her weight minimized her intellect and efficacy as a therapist. She said, "I always wonder are people going to say, 'Oh, I don't want to see her because she doesn't have her shit together because she's fat!'" The assumption that fat people are unintelligent could be one explanation as to the dearth in research that includes fat people as participants with knowledge to share.

Discriminatory assumptions and ideologies about race, disability, gender, and other identities may also speak to the lack of diversity in sample sizes within the few studies there are on fatness. Moving back to Stacy's comment, she highlights the associations among fatness, laziness, and moral failing. According to Stacy, it feels as though she could not be both fat *and* a good therapist.

A few participants linked their fatness to their sexuality. Maddy, for example, told me a story about her first time seeking birth control and the disbelief her doctor had when confronted with a fat teen actively engaging in sexual intercourse. Details of this experience are expressed in later sections of this thesis. Another participant, Caroline, a 52-year-old White woman, told me, “I’m somewhat invisible, you know? I’m invisible to men. Or I am looked at quickly and placed into a category.” When it comes to sex, it seems as though the only categorical options for fat women are either as assumed asexual creatures or as fetishized objects. Though some fat women may be asexual, the assumed nature of this and purposeful desexualizing does not give her control of her own sexuality. In fact, neither of these hyper or hyposexual categories make room for a fat woman to decide what pleasure, desire, and sex mean to her.

Layla, a multiracial Black PhD student, emphasized not merely an invisibility, but a dismissal of fat people’s worth as contributing members to society. She said, “[If] we can’t be readily identified as productive, then we immediately lose our value in a [capitalistic] society.” In this, Layla links fatness to the social perception of fat people’s (in)ability to work, and then links this to productivity and capitalism. If a group of people are so stigmatized in a society that they are viewed as valueless, it becomes clear how discrimination of this population becomes so normalized that it blocks any life chances (Goffman 1963; Farrell 2011). When job opportunities, educational opportunities, and even health care are all barred and blocked, what else is there to feel but invisible?

Another reference to the invisibility of fat people includes the lack of inclusive design of or within many social settings, clothing garments, and furniture. Several participants noted that fat people are treated as second-class citizens who have little to offer society. Thus, certain opportunities, locations, and experiences are made inaccessible to fat folks. When addressing

this, many interviewees described the lack of inclusive clothing sizes, the discomfort in armed chairs and public seating at restaurants or sporting events, and inadequate health care equipment like MRI machines or blood pressure cuffs.

My participants also noted that fatness, particularly the fat body itself is hypervisible. Contrary to the ads by the shapewear industry that attempt to sell the concealment of fatness to fat women, there is very little one can do to hide their fat other than hiding the self entirely. Even in online spaces where one has a better chance at concealing their body, there is still pressure to remain viscerally hypervisible. For example, Caroline mentioned the necessity to *out* oneself as fat on dating apps. This form of outing is different from what Saguy and Ward describe in their 2011 article on the coming out narrative for fat people. In this, they describe the reclamation and rebellion of being an *out* fat person. What Caroline is describing is the expectation that fat people, particularly fat women must disclose her body size to potential suiters as soon as possible. This might happen through strategic choice in picture display, ensuring that her dating profile has photos that adequately present her body to reflect her fatness. It might also happen in her bio. Here we might see her choose the euphemisms mentioned at the top of this chapter such as “plus-sized,” “big girl,” or even “bbw” which stands for big, beautiful women. Though women’s bodies are objectified and harshly critiqued in general, the expectation to *out* one’s body type on dating apps is not an expectation felt by non-fat women.

A key idea that various participants described or alluded to was how this hypervisibility seemed to give others a sense of social permission to tell fat people things about their bodies that are damaging, stigmatizing, and discriminatory. For example, Stacy, a White mom of four, told me a recent story of being a fat woman living through the COVID-19 pandemic. One day, while in Target, she and her children were fully masked and standing near the candle section of the

store. One of Stacy's daughters turned to her and said, "Careful, mom! It's [the candle] is really strong." Stacy cheerfully replied, "I've got my mask on. It's not going to knock me out." As this conversation was happening, a thin White woman wearing yoga attire and no mask loudly said to Stacy, "If you weren't so damn fat, you wouldn't have to worry about getting sick." After she told me this, Stacy and I stared at one another in disbelief, confusion, and frustration. Stacy could not understand what compelled this other woman to say something so degrading to her, in front of her children no less. She said, "I don't know if she thought I was making a comment about her not wearing a mask, but I was just telling my kid that the candle scent isn't going to knock me out." A part of this experience that frustrated both Stacy and me was the fact that one of her children, who was present for this comment, exists in a similarly shaped body as her mom and assumed this woman was talking to her. Thus, showcasing that fat stigma is not merely a problem for fat adults.

Another important part of Stacy's story is the implication behind the random woman's comment: *if you weren't so damn fat, you wouldn't have to worry about getting sick*. This single comment conveys so much about this woman's understanding of fatness and health. Moreover, this story exemplifies how medical discourses are mobilized outside of health care spaces by policing bodies deemed to be deviant, unhealthy, and inadequate (LeBesco 2011; Murray 2008). Participants shared with me that it does not feel like anyone believes that fat people care about our health or the quality of our lives. They also noted that there is the assumption that fat people are inherently unhealthy merely by living in a fat body. Thus, much of the day-to-day and health care experiences of fat folks involve immense critique of the way they manage their health. Roxy, a 35-year-old White woman said, "We're supposed to have accepted that we are doing a

bad job. We are less than and we need someone to tell us how to do it better. [Society will] make you feel bad until you take care of yourself in the way we think appropriate.”

The troublesomeness with these health-related assumptions, as detailed in later chapters, is that the health care field rarely provides safe and appropriate care to their fat patients. In fact, Amy, a White woman with a 30-year career as a nurse, confirmed that some medical personnel joke about and degrade their fat patients when they are out of earshot. She said, “I have seen so much...so bad. You know, like the way surgeons talk about their client’s bodies when they’re under anesthesia. I’ve seen the bad treatment they [fat patients] get. I’ve seen the looks. I’ve watched colleagues do it for decades.” Amy’s inside knowledge validates so many fat patients’ worst fears about their doctors, surgeons, and nurses. Through angry tears another White participant, Anne said to me, “society makes it seem like fat people are unlovable...unworthy of love, unworthy of care.” Thus, we are left to wonder how we fat people are expected to care for ourselves in a society that has shown it does want to nor does it know how to care for us.

A central idea that emerged from the data was the sense that fat people are viewed and treated as moral failures. Amy added to this by highlight how fat people are made culpable for our size. Rarely is there any space, outside of the fat acceptance movement, for acknowledging the socioenvironmental creation of the fat body. It is deemed more appropriate, and in fact it is encouraged, to harm oneself into a smaller body than it is to accept the large body as it is or to recognize the social contributors to fatness. A large reason for this, as described by multiple research participants and most plainly said by Roxy, “At a very underlying level Americans broadly, and probably a lot more people than just that culture, are terrified of becoming fat.” This fear comes from the recognition of inadequate and actively harmful social treatment, the assumptions around quality of life for fat people, and the intentional public health facilitated

scare tactics surrounding fatness and health status. Ultimately, there are very few social ideas around fat people that are life affirming.

Conceptualizing Healthy: A Dynamic Spectrum

Because many in the U.S. synonymize fat with unhealthy without a question or doubt, it felt pertinent to understand how fat individuals conceptualized *health*. Largely these individuals understood health to be a spectrum founded on more than just bodily metrics such as blood pressure or cholesterol. Many mentioned that health status is much more than just the physical and aesthetic aspects of the body. Health status is also comprised of mental, emotional, social, and spiritual wellness. The bottom line for these participants is that health is more complex than what one's bloodwork might say.

Most of my participants conceptualized health around how they felt whether this was physically, emotionally, mentally, or otherwise. For example, Stacy described the treatment she received while she was pregnant. Stacy has been a fat woman before, during, and after all four of her pregnancies. For the first one, she followed the entire regimen suggested to her by her obstetrician. This primarily included a very specific and highly restrictive diet plan. By the end of this pregnancy, Stacy acknowledged that her quantitative health metrics were stellar, but she didn't *feel* well. In fact, not only did she not feel good, but she also ended up dehydrating after following these diet instructions. She questioned, "So, how is that healthy? If it puts so much stress and strain on me and my brain and my body...Is that better for me?" A common desire for many participants was a balance between their quantitative health metrics and their qualitative ones. Said plainly, these women wanted to have their own perception of how they were feeling to be acknowledged during their health care appointments.

A point of frustration for many research participants was the way fatness has been treated as the primary health issue in one's life and that most treatment plans are primarily based on weight loss. Though this will be further detailed in later chapters, research participants highlighted the hypocrisy and confusion of health status in the U.S. For example, Roxy described one of her more recent annual physicals where all of her "numbers" came back great. Her blood pressure was great. Her blood sugar was doing fine. Her cholesterol was not only optimal but had actually improved. Yet, even when these more objective measures were met, her doctor chose to end the conversation with a comment about her BMI still being high, the weight she gained throughout the pandemic, and the recommendation of engaging in intentional weight loss. Roxy described her confusion, "So, what is the definition of healthy now? If we have concluded that I am healthy...But, but my gravitational relationship to earth is greater than someone else's, but I'm still healthy? I think we're going to go ahead and say I'm healthy!?"

Participants were also clear in stating there is little-to-no capacity for knowing someone else's health status by looking at them alone. As one White participant, Anne said, "You don't know [if] other people are healthy. It's just an assumption that we make based on perception." There is an assumption, both as individuals and within health care settings, that one can determine another's health merely by looking at that person's body. However, these participants emphasized that health status is often an unseen or internal part of the human condition. Health is not merely found upon the skin. These thoughts and ideas that my participants expressed are in direct opposition to the medical gaze. The essence of this gaze is to make things transparent. As mentioned in earlier chapters, medical authorities use the gaze to filter and separate biomedical data from the non-biomedical to efficiently diagnose and treat a patient. However, the fat body is

already confounding the gaze. Because of the fat body's fleshiness, there is both more and less to be seen on the skin.

CHAPTER V: HEALTH CARE PROCESS

In this section, I detail the health care process that my research participants retroactively described to me. I begin with the details of my participants' appointment preparation activities. Some participants did not engage in preparation, where others spent a large amount of time and energy getting physically, mentally, and intellectually ready for medical appointments. Following this, I address both the negative and positive health and medical-related experiences of my research participants. Though much of our time together in our interviews was taken up by descriptions of harsh treatment, traumatic encounters, and annoying barriers, my participants did share some positive stories with me. Many of these stories were experienced first-hand, and some participants also described their friends' and family members' experiences that were relevant to this research. Finally, I conclude this chapter with a description of my participants' post-health care encounter rituals. Interestingly, while many participants had much to say about their preparation for appointments, they generally had little to tell me about what they did after visits. Many of them said they just went back to their daily lives at the conclusion of their appointments. This section on my participant's health care processes provides some insight into the experiences of fat women navigating the U.S. health care system.

Preceding Health Care: Feelings & Actions

Many of my participants expressed that their health care process did not simply start at the beginning of any given appointment. Instead, they described a fluidity between appointments where one visit informed the next. This fluidity was highlighted primarily in their discussions of negative appointments. Most participants described how adverse health care-related situations, whether experienced first-hand or vicariously through online posts and authors' or activists' published works (See: Gordon 2020; Hagen 2019; Tovar 2018), evidenced the necessity for preparation for their next appointment. I consider the emotional sensations, the physical tending

these women did to their bodies and appearance, and any intellectual labor conducted before an appointment or visit to be preparation. Some of this preparation was an active choice, such as their decisions around how to dress for their visit. Other parts of their preparation were less actionable, such as the sense of fear many of the participants described feeling before some appointments. Preparation looked different for participants based on one's intersecting social identities, the type of appointment, and their prior of stigmatized treatment in health care settings.

Three of my participants stated that they do not currently or actively perform any preparation practices. I would argue that two of these women did unconsciously engage in emotional preparation, as they both described feeling anxious before some appointments. In fact, later in this section, I use some of their words and expressions to describe other forms of preparation. However, they did not acknowledge this themselves. A shared reason among these women for their lack of preparation was the acceptance they grew to have for their bodies. Two White women, Amy and Patricia, attributed their lack of urgency around preparation and the acceptance of their bodies to their study of and participation within fat-focused social movements (e.g. Fat Acceptance, Body Liberation, etc.). Though neither of these two described themselves as activists, they did mention being part of online groups that aligned with the overall mission and values of the Fat Acceptance movement (see: Cooper, 2016). For these participants, Fat Acceptance touched them in a way that transformed how they moved through the world. The third participant who did not claim to engage in preparation, Ella, was unfamiliar with Fat Acceptance or any other fat activism work. Thus, the acceptance she had of her body was derived from self-guidance and personal choice, rather than from finding community in fat-positive spaces. Ella's lack of preparation is also linked to a lack of time for preparation. As a

mom and full-time childcare worker, Ella plainly stated that she does not have the time to prioritize health care appointment preparation. This lack of preparation should not be confused with a lack of care for her health status. Ella cares greatly about her health, and she does not feel any urgency in preparing to defend a body that she accepts as it already stands.

Anxious & Afraid: Navigating Emotions Pre-Health Care Encounters

One of the first things I asked my research participants to do in their interviews with me was to describe what they felt when they imagined making or attending a health care appointment. Whether this appointment was a wellness check-up, a therapy session, a dental exam, a surgical procedure, or any other health-related visit, I wanted to understand what kind of emotions these women navigated before they even engaged with any doctors, nurses, or other health care staff. The most common responses were that they felt scared, nervous, and anxious about going to and scheduling these visits. A devastating comment came from 52-year-old, White participant, Caroline. At the time of the interview, Caroline mentioned experiencing certain conditions that require surgical procedures as treatment. Because of this, she said her main thoughts around her health care appointments are, “I hope I survive the next anesthesia.” For Caroline, this fear is not founded on the common risks involved in any anesthetic procedure. Instead, she is fearful of the treatment of her fat body. Caroline elaborated on the discomfort she feels when she thinks about her “large, unconscious body” having to be maneuvered by surgeons and other medical staff. She does not believe that these individuals care about her and therefore, she has no confidence in them doing much of anything to save her life in an urgent situation. “It’s always underlying that this larger body is always an inconvenience at best to the medical industry” she said.

Caroline's comments highlight the overall health appointment anxiety that other participants shared with me. Moreover, her comment reveals much about the immense fear that fat people have of not being appropriately cared for when our lives depend on it. The way these fat women talked about their bodies via a medicalized perspective illuminated their perceptions of how much health care providers loathe their bodies. They have been left to feel like they are unworthy of adequate health care. Because this study's research participant sample is comprised primarily of White women's experiences, it must be identified that even within these stigmatizing experiences, their Whiteness still acts as protection against other racist forms of medical discrimination. Fat stigma is a violently oppressive system, and it disadvantages all people, whether an individual is fat or not. Yet, it cannot go without mentioning that fat stigma experienced by White individuals can be, and often is, vastly different from fat stigma experienced by Black, Indigenous, and other Folks of Color. This is primarily due to the racism embedded in fat stigma that White individuals do not have to navigate. Essentially, because of the way race and racism operates in the U.S., White fat women do not have to experience life, health care, or fat stigma in racialized fat bodies (Meerai 2019). Referenced earlier in this written work, professor Sonia Meerai (2019) spoke to some of this in an essay found in the anthology *Thickening Fat: Fat Bodies, Intersectionality, and Social Justice*. Meerai wrote:

Under the auspices of medical discourse, my racialized fat body is taken up in particular ways. I am told that I am too broken to live and marked as a danger if I do not conform to what is deemed healthy. The distortion within medical discourse of what is healthy becomes complex at the intersections of disability, race, gender, and class, among many other identity markers (2019:92).

What my participants' narratives convey is a lack of trust in their health care providers. Therefore, it is unsurprising that questioning the necessity of the visit was a central theme that emerged from these participants' responses. For example, Amy shared with me that she tends to

avoid appointments due to her recent history with medical personnel. Although Amy described feeling at home in health care settings, because of her 30+ year career as a nurse, only recently has she been made to feel uncomfortable, if not unacceptable, in these locations. She has been made to be her own medical advocate and case manager, even going so far to write her own case notes to present to doctors and specialists as she sought treatment for medical conditions. She explicitly said that, unless she cannot handle it on her own, she refuses going to any doctor, especially for orthopedic-related issues. “Trying to get an orthopedic doctor to listen to a fat person is impossible,” she said. “I just deal with it. I just don’t go to the doctor for that kind of shit. I put it off.” If they did not fully avoid their appointments, some patients would intentionally schedule or cancel and reschedule them for faraway dates. For instance, Stacy told me “I want to push it [an appointment] out a little bit further...because I don’t want to get yelled at.” What Stacy unveils here, as many other participants noted, is that there is more to these feelings of fear and unease than just being denied care. There is also the fear of repercussion simply for being fat and seeking health care.

Some of the other common emotional sensations that these participants described feeling included exhaustion and stress. Many participants described an unease at the thought of people watching them come into health care facilities and doctor’s office waiting rooms. We, as fat people, tend to be hyperaware of the moral and social assumptions ascribed to our bodies. My participants noted that this awareness increases within health care appointments. For instance, Martie told me that she felt like anyone in the waiting room of a health facility, patient, or employee, assumed that she was there to “not be fat anymore.” For Martie and other research participants, this idea that these women are in medical spaces to lose weight is not merely a fear-based assumption. Instead, my participants shared with me multiple stories of having their

corpulence made the center of their health-related appointments, even if the appointment itself did not have to do with their weight in the first place. More specifically, weight loss was made a primary objective, usually without permission or expressed interest in this conversation from these women.

Because we must move through a world that stigmatizes our bodies for merely existing, it is not uncommon for fat people to internalize this stigmatization (Lewis et al. 2011). My participants, through their stories and commentary, have explained that they are walking into these socio-clinical settings, like waiting and exam rooms, already feeling inappropriate, alienated, and unworthy. Furthermore, they have little-to-no control over these stigmatizing perceptions. Although many women in this research described their preparation as protective strategies, this is not the case for every fat person. In fact, it is possible that some fat people would begin to believe that some of this harsh treatment that we experience is deserved. Patricia, a White professor at U.S. higher education institution, described this exact feeling. Although she's part of Fat Acceptance groups on Facebook and has read about this social movement, even she falls prey to this idea of a deserved punishment. Before some appointments she has thought to herself, "My body shouldn't be this big. They shouldn't accommodate to this big body." Because the health care industry is generally not life affirming to fat people who accept their bodies, Patricia sometimes wonders if she is even right to accept her body at all.

To combat these feelings, a few participants described their preparation process as one that involves affirming and calming themselves. Layla, for example, was enthusiastically vocal about her pre-appointment affirmations and the emotional support she requests from her partner. She described her affirmation process as one that removed blame for any decrease in her health metrics and any negative health encounters that she might be confronted with. She will say things

to herself like, “You can’t be mad at yourself because being mad at yourself doesn’t help you reduce your blood pressure. It doesn’t help you get all of your other metrics in line. So, let’s not be mad at ourselves. Let’s go in there and be ready to ask questions.”

Data collection for this study occurred after the Summer of 2020, when racialized violence and the murder of Black individuals became the center of media attention. This is not to say that this violence was not already happening, but the violence was exacerbated by the pandemic and was more directly talked about on social media and within news media. Layla’s preparation, therefore, involves the absolving of self-blame for the negative consequences of the racialized stress that is forced upon her and other Black women and individuals. Following her internal preparation, Layla’s partner will also affirm her before entering the appointment. She mentioned that her partner will say things like, “You’re going to be great! You’re going to be amazing! Everything’s going to be okay! You’re going to get the answers you need.” White participant, Martie also mentioned bringing her partner to appointments. Although she doesn’t necessarily feel compelled to bring them into the appointment with her, their presence before the appointment is supportive and calming. Both Layla and Martie acknowledged that their partners’ presence before and after their appointments gave them a sense of safety and comfort.

Preparing to Endure: Conforming & Challenging Actions

For those who did feel a need to prepare for their health care appointments, none described any part of their preparation as optional. Instead, as these fat women work against the backdrop of anti-fat rhetoric and assumptions that construct fat people as ugly, unclean, and unworthy of care, preparation feels mandatory. Around half of my participants referred to preparing for health care appointments as a “gearing up” or a protection process. These women prepared because they felt a need to brace themselves for stigma, moral judgement, invalidation,

and inadequate treatment. For instance, White participants Roxy, Patricia, and Amy explicitly mentioned developing rebuttals that they kept in their proverbial back pockets at the ready. Whenever a doctor attempted to use weight loss as a treatment plan or a barrier to access, these three fat women will respond by asking something like this: “If I were a thin patient with the same conditions that you are seeing now, what would be your medical advice and treatment plan to me, then?” According to the three, this is a common tactic promoted in online fat acceptance spaces. Ultimately, this question confronts the care provider in a way that gives these fat patients a sense of control, or at the very least collaboration, over their appointment, the conversation, and any treatment plans for their symptoms and diagnoses.

My participants described more than just developing rebuttals to use in their appointments as preparation. In fact, preparation, as these women described, included a grand mixture of emotional, physical, and intellectual preparation. For the remainder of this section, I focus on the latter two forms of getting ready for an appointment. An overarching theme to physical and intellectual behaviors was that they are overcompensating in nature. All but one participant conveyed that they felt as though they had to do more because of their fatness. Though all of my prepping participants engaged in overcompensation, these behaviors can be further separated into two categories: conforming and challenging behaviors. None of my participants explicitly described their preparation as conforming or challenging; nevertheless, the steps they took to prepare themselves for these health care encounters seemed to aid in the preservation of the *compliant* fat patient (conforming) or demonstrate a sort of rebellion against the dominant ideas about fat people (challenging).

There are two important notes about categorizing my participants acts of preparation in this way. First, my participants did not exclusively demonstrate just conforming or just

challenging behaviors. In fact, many of them described enacting both types of behaviors throughout a preparation process. For example, while some participants might have rebuttals ready to defend themselves and advocate for appropriate treatment, some of these women are the same individuals who are very attentive to the clothing and shoe choices they make so that they look like a presentable, and therefore compliant, patient. Second, there is not always a clear line between compensating as an act of conformity and compensating as a challenge. For example, Anne was one of my participants who had described the necessity of showcasing one's intellect in order to receive appropriate health care. She explained, "I need to educate myself on that subject beforehand and I need to use a couple of medical words that make me sound smart." This might be viewed as conforming, because Anne is conforming to the notion that her fat body is making her an inappropriate patient (van Amsterdam and van Eck 2019). Additionally, it might be understood as challenging, because Anne is also attempting to counter the idea that fat people are lazy and ignorant by showing how she understands the symptoms and conditions she's experiencing (van Amsterdam and van Eck 2019).

In the previous section, I mentioned how fear was a common emotion that my participants described feeling before health appointments. Some participants described fearing appointments so much that they would deeply question the necessity of attending the appointment. Sometimes this led my participants to either neglecting the scheduling of a health care appointment or the overall avoidance of attending the visit. For example, Stacy was one who mentioned that she would push her appointments out as far as possible. However, Stacy was not the only participant to do this. Layla, told me, "I don't like getting blood work because I'm always afraid that I haven't done enough to get all of my numbers into a healthy range." For both of these participants, there is the fear of repercussion for their bodies. More specifically

identified by Layla, there is a fear of having not conformed enough to mitigate medical personnel's potential disappointment, disgust, or anti-fat infused lectures. Furthermore, as a fat, multiracial Black woman with a diagnosed health condition, Layla has experienced the achievement of a healthy status is blocked by numerous cultural and racial barriers (see: Meera 2019).

This fear of “not having done enough” led participants to act in different conforming ways. Though some of my participants explained that they have given up most of these behaviors, it is still valuable to understand that they were once a normalized part of the health care process for these women. Some of these acts included taking vitamins, decreasing food consumption days in advance of a scheduled appointment, and putting pressure on themselves to lose weight before their next appointment. When asked about her preparation process, White participant Bianca described to me the fear she had growing up, and that still lingers, about weight gain. She candidly exclaimed, “God forbid you gained weight! Like, shit! If I gained in-between doctor's appointments, I would be so stressed out that I would be ripped into [yelled at] for it.” Another White participant, Maddy had similar things to say. She shared with me, “I would maybe not eat very much in the two or three days leading up to a doctor's appointment so that I could weigh the absolute least I could possibly weigh before going to an appointment.” My participants emphasized this fear-induced need to reduce their weight, and in many ways themselves, in order to be understood and treated as an obedient patient. Even for my participants who described having accepted their bodies, weight-based fear was an activator for conformity to the interests of anti-fat bias.

Some of the other acts of physical preparation that my participants described included taking time to prime their bodies and appearances. For Caroline, this meant ensuring her body

was clean and odorless. Whereas for Maddy, this meant being careful about the clothes or shoes she wore to her appointments. Prior to the birth of her children, Maddy shared with me that she would “consider what shoes I was wearing, so my shoes weren’t extra heavy on the scale. I would dress in lightweight clothing.” Though neither of them said this out loud, both Caroline and Maddy’s preparation indicate their understanding that their fat bodies mark them as failed, inappropriate health care patients. Since the birth of her children, Maddy has described a shift in her perception of her body⁶ and mentioned that she no longer cares what she wears to appointments.

Though the majority of the preparation practices that my participants described were compensatory, there was one behavior that did not quite fit into this category. A quarter of my participants described engaging in meditative deep breathing techniques to calm themselves before appointments. This act of care helped alleviate these women of some of the stress and anxiety they faced before and during their health care appointments. I consider these intentional moments of self-caretaking to be challenging in nature. Because the health care systems, among others, are not life-affirming for fat people, any act of self-care, even the smallest ones completed by fat people can and should be considered acts of challenge and resistance.

These women did not merely mentally prepare, but intellectually overprepared for their appointments. My participants highlighted a pressure to disrupt the assumed lack of intelligence associated with fat bodies. One intellectual tactic described by a third of my participants was writing down and bringing in a set of concerns and questions to pose to their doctors. Layla mentioned that she would have a notepad not only for her questions, but to take notes on what

⁶ Though outside of the confines of this research, there is something to be said about fat motherhood and re-consideration of the body post-partum.

her medical care providers were explaining to her. Anne, a White participant who wrote questions, told me that the reason she prepared her questions was so that she could sound astute. Anne's comment underscores the need for fat people to not only appear competent via preparedness, but to also sound smart in the language used in these settings. Bianca explained to me that the reason she wrote questions down for her health care visits was not just because of her fear of anti-fat bias. She added, "I'm just the type of person who [gets] really anxious, especially with asking for help or with asserting my needs. And especially when it's in a setting where...this person is like the 'experts' or the 'professional' and I'm supposed to take their word as the gospel and not question them." In describing this, Bianca highlights the assumed social contract between health care providers and patients. This is that the medical professional is the expert, and their advice is more legitimate than any concern that the patients might have.

Some participants also essentially described conducting literature reviews of their symptoms and potential diagnoses. Roxy said to me:

I have had many instances, and I suspect many women have and many fat people have, of not having my symptoms taken seriously...Or of being assumed to be just the result of being in a fat body...Or that I am overstating symptoms due to anxiety in some way. And that has often required me to not only be my own advocate, but in many cases, my own diagnostician and doing research on my own to identify what I am dealing with.

Maddy also described conducting research in order to prep for her appointments, exams, and visits. Sometimes this research would be about her conditions or symptoms. However, Maddy had a stronger emphasize on investigating her doctors and any research that they themselves conducted. She'd then try to integrate said research with intentional eloquence into her conversation with the medical practitioner. As if talking to a doctor, Maddy said to me, "I'm pretty sure you're not going to value me as a human because you're a doctor and I'm fat, but maybe you can value me as an academic."

Some participants mentioned how they'd actively look for providers who they thought might be more receptive to their identities, conditions, and bodies. For example, Lynn, a 25-year-old Black woman, shared with me how she'd spend hours researching different doctors in her city before making any type of appointment. This included scouring a health facility's directory for photographs, biographies, and reviews left by past patients. Lynn was searching for quality care and took into consideration the race, gender, and size of any potential health care providers. Lynn has yet to experience any health care provided to her by a fat, Black woman doctor. Though seeing a doctor who holds these three identities would not guarantee her a stigma-free experience, Lynn emphasized that it would bring her a larger sense of safety and comfort in these appointments. Unfortunately, Lynn has often had to compromise her safety and comfort in order to access her appointments. It becomes a matter of having to persevere through any potential medically driven racism, sexism, fatphobia, or a mixture of these in order to access her needed health care. Though my White participants didn't speak to this sentiment entirely, many of them did share they prefer a fat doctor over a thin one. For instance, Roxy, a 35-year-old White woman, said she sometimes is left to look for fat doctor's "on the assumption that maybe they will not be self-hating fat people." Ultimately, Lynn, Maddy, Roxy, and other participants in this study feel as though they have to put in extra work to account for these health care provider's lack of preparedness in serving fat patients. Essentially, what I have described in this section has been some of the ways that my participants are managing their "spoiled identity" (Goffman 1963).

Characteristics & Impact of Negative Health Care Experiences

In this section, I detail the characteristics, patterns, and impacts of negative, stigmatizing, and discriminatory health visits as described by my research participants. This section is split

into four sub-sections. The first, titled “Feeling (Un)Welcomed?” covers my participants’ experiences with navigating environmental stigma. The second sub-section addresses my participant’s experiences with having their health care providers’ assumptions about fatness guide and inform their services. The third tells my participants’ stories related to their health care providers not having an adequate understanding of how to treat their fat bodies. Furthermore, this sub-section highlights the delegitimization, the trivialization of one’s knowledge and perceptions of their illness or condition (Ware 1992), these women endure during medical encounters. I conclude this section with how my participants have experienced weight loss advice as treatment, in and of itself, or as a barrier to appropriate medical treatment

Feeling (Un)Welcomed?: Assessing structure & equipment

Researchers have conceptualized stigma and discrimination in a myriad of different ways (see: Link and Phelan 2001; 2006). Because I am not concerned with naming the specific forms of stigma that my participants faced, I do not go in-depth with stigma categorization. However, an unexpected topic that cropped up in my interviews with my participants was navigating environmental/structural stigmas in health care settings. Because of the frequency with which this was brought up, with nearly all my participants mentioning something about inadequate seating or equipment, I dedicate this first section to this topic. I borrow from both Link and Phelan’s (2001; 2006) work and Lewis et al. (2011) to conceptualize environmental/structural stigma.

In Link and Phelan’s 2001 article “Conceptualizing Stigma,” they define multiple categorizations of stigma and discrimination. One of these categorizations was structural discrimination. They refer to this as structural or institutional practices that work to disadvantage stigmatized groups. They wrote, “Stigma has affected the structure around the person, leading

the person to be exposed to a host of untoward circumstances” (Link and Phelan 2001: 373). I combine this with Lewis’s et al. (2011) definition for environmental stigma which is simply “stigma associated with the physical environment such as unsuitable seating” (Lewis et al. 2011: 528). I refer to this stigma as either environmental stigma or structural stigma throughout this section.

Having to navigate the environmental stigmas within health care settings can cause a sense of difference, deviance, and isolation for fat patients (Lewis et al. 2011). For example, 35-year-old White participant, May shared with me her fear of exam tables that aren’t bolted to the floor. She said, “Sometimes when I stand on the little step to help you get onto [the exam table], the back of the table will come up off the floor because there’s so much weight on the front.” She continued, “Things like that, cause me anxiety because I know that they’re not prepared for people of my size.” May was not the only participant to share these types of feelings and experiences with me. Having to watch a nurse dig out appropriately sized equipment from the very back of the supply closet, having to call around to different hospitals for an MRI machine large enough to accommodate a fat body, or being made to stand in a waiting room because there isn’t a chair that can adequately support one’s weight all emphasize the lack of consideration for fat patients when designing health facilities. Environmental stigmas such as these reinforce the fat body as both non-normative (Lewis et al. 2011) and hypervisible to the medical gaze and the average social citizen.

In line with findings from Lewis and colleagues (2011), my participants expressed their frustration around the usual lack of appropriate seating in most health care facilities. Whether a waiting room, exam room, or clinical office, my research participants shared with me how unsurprised they felt when a chair did not accommodate their size. There are usually few

appropriate solutions for addressing moments such as these. Heidi told me how when she would go to certain health care visits, she would have to choose between a chair that would physically hurt her body to sit on, or a window ledge. She always chose the window ledge, even if the nurses and other medical staff looked at her in confusion. Another White participant, May, told me about a time when she attempted to confront someone about the lack of appropriate seating options in an orthopedic office. A few years ago she was dealing with some painful knee problems. After walking into the waiting room of this doctor's office, she realized none of the chairs in the waiting room were going to fit her body. They all had metal arms and as May said, "[the chair] would have been incredibly painful if I tried to wedge myself into one." To deal with this, May asked the receptionist if there were any other chairs for patients to use. After asking this question, May said the receptionist's face was contorted in absolute confusion. The receptionist became flustered and asked May what she was talking about, admitting that she didn't understand the question. May plainly told her, "I can't fit in those chairs. They all have arms. My knee is very sore. I need to sit down, and I can't fit in any of these chairs." After this, the receptionist became even more flustered and began hurriedly seeking a more accessible chair. Unsurprisingly, there were no other chairs in the facility. Because of this, May was taken to an exam room earlier than anticipated. Initially, May was grateful for the accommodation. However, even this so-called solution presented problems. May explained, "The exam room table was very high off the floor and the little stepstool that they had to help people get onto the table was not one that I thought was safe for my weight...We solved half of the problem." Although medical professional and staff have demonstrated their awareness of fat bodies through their dehumanizing critiques and comments, this awareness is shallow at best. Their awareness is of the hypervisibility of the fat body and the stigma ascribed to it, but not the lived experience of

the fat body. This becomes most obvious when confronting medical staff about their facility's lack of an inclusive environment. As another White participant, Bianca stated in regard to environmental stigma, "Most spaces, most clothing, most opportunities are not created with my fat body in mind."

Appointments that involved blood pressure testing were some of the most commented on and critiqued parts of health care encounters, right after experiences of being weighed. My research participants informed me of the frequency with which health facilities provide inadequately sized blood pressure cuffs and of the inconsistency in staff competency. Anne talked about having multiple bad experiences with having her blood pressure taken. She said, "I've been to the hospital, and they've used the wrong size cuff! And they kept telling me, 'Oh, your blood pressure is really high.' No, shit! This is the wrong sized cuff!" In Anne's case, her high blood pressure reading was due to inappropriately used equipment, and therefore was a failure of the health care facility. Nevertheless, she was made responsible for the facility's shortcomings. Another White participant, Maddy shared, "At one point they had a [blood pressure] cuff that was meant for a thigh on my arm. And I was just like, what is wrong with people that no one has invented a cuff to fit a person's arm the size of my arm? Why are we not doing this?" Maddy's experience highlights how environmental stigma can be both frustrating and other for stigmatized individuals.

Another participant who shared a blood pressure story with me was Heidi. Her experience had less to do with the equipment itself, and more to do with the incompetency of certain nurses who she has to interact with at her doctor appointments. "Some of the nurses...are very bad at taking my blood pressure. I had one, she was just like totally guessing what my blood pressure was. It was clear because she was like, 'I can't hear the top number.'" Though this

theme is addressed in a following section, Heidi's story highlights how some health care workers have no idea how to care for and work with fat bodies. These failed blood pressure assessment stories highlight how structural stigma is reinforced in both physical contexts and from the inadequate care coming from health care employees.

Some participants also addressed the embarrassment and frustration of receiving inappropriately sized garments in health settings. Heidi shared a deeply emotional story with me about one of her fellow fat friends who was experiencing a mental health crisis that involved seeking emergency support. Because this situation involved suicidal ideation, Heidi's friend was instructed to remove his clothes and wear the facility-provided clothing. However, the facility could not actually provide him with a new set of clothes. He told Heidi, "They didn't have anything to fit me. I can't do that again."

Lynn and I also spent quite a while discussing a situation she experienced at a chiropractic office that involved a similar clothing problem. Following a car accident, Lynn had been dealing with intense back pain and sought the help of a chiropractor in her area. When the appointment began, Lynn said she felt pleasantly surprised that they did not weigh her. These feelings, she said, did not last. Because it was the first appointment, the chiropractic staff had mentioned that there was a chance of needing to X-ray her back to fully assess the present issues. Lynn wore a pair of jeans to this appointment, and because of the metal on her pants, the chiropractic staff offered her a pair of cotton shorts to prevent any disruption during the X-ray. However, the shorts they gave her were, as Lynn described, obviously too small for her body. They were so small that a large part of her buttocks, at least 3-4 inches, hung out of the shorts. Lynn assumed this was the largest size they had and figured there was no use in requesting different shorts. In addition to this clothing debacle, the only chair in the exam room did not fit

Lynn's body. Thus, Lynn was made to stand up, wearing shorts that forced her bottom to protrude out of them, while experiencing harsh back pain for well over thirty minutes. The part of this experience that frustrated Lynn the most was that they never even conducted the X-ray on her back. Lynn was made to wear these uncomfortable shorts for effectively no reason. Environmental stigma can make fat patients feel as though they are being punished for deviating from the norm.

Although Lynn and I both laughed about this story during the interview, this laughter was not so much because the situation was funny. Instead, this laughter felt like a way to cope with the continuous stigmatization of fat women's bodies. It is clear that this chiropractic team had absolutely no awareness of Lynn's true size or her comfort level in using their chairs. Fat patients, on the other hand, are hyperaware of these things. As Lynn, herself, said:

We [fat people] think about every single thing every day. Will this chair hold me? Is this bed frame sturdy enough? Knowing my weight, can I use this exercise equipment? Can I buy the stepstool, or is it going to break? It's always a negotiation of size and weight. Every single day.

Though my participants shared multiple stories of navigating environmental stigma and the negative impact these moments had on their overall health care experience, there was not a consensus on whether they felt welcomed in health care settings. The only common link among these perceptions was that this welcome-ness was conditional. That is, if they felt welcomed at all. Some participants didn't know they had any feelings around this subject until I asked them the question. For instance, Layla told me, "I don't know if that's something I've ever thought about. Yeah, because I'm so focused on myself when I'm there." Similarly, Patricia didn't realize she harbored any feelings of unwelcome-ness until I asked her about it during our interview. After asking she said, "That's a really good question. I just feel nervous. So, I guess kind of unwelcome? Yeah. I think unwelcome." Whereas White participant, Anne told me right away

that she did not feel welcomed. Others said that they did sometimes feel welcome, but again, this welcoming was under certain conditions. When I asked Stacy if she felt welcome in most health care spaces, she said, “I would say, yes, because I at least pretend to be a compliant patient.” Martie acknowledged the identities she has or had that have influenced her feelings around health care. Martie told me that she was not always fat and that her prior thinness coupled with her access to health care via health insurance and being a White woman instilled a sense of deservedness in her. It did not really matter if she felt welcome because she knew that because of the social perception of these identities, she was treated as someone who deserved health care. Since having multiple transitions in health insurance over the years, developing her understanding of the privileges of existing in a White body, and having become a fat person, Martie now acknowledges that regardless of feeling welcome or not, the way our health care system is set up to dehumanize the majority of health-seeking individuals, especially if those individuals do not fit dominant body standards.

Researchers, Kinavey and Cool (2019) understand bodies to be sites of injustice and therapy rooms as likely sites of injury. I extend this notion to any and all health care and wellness spaces. Intentional or not, it must be acknowledged that many people are harmed in health care settings. Specific to this research, each of my research participants could tell me at least one, if not multiple, negative experiences with a doctor, nurse, or other health care staff member. The stories collected and told in this written work range in a variety of ways. Some of my participant’s stories were from childhood, and others happened the week prior to my interview with them. The sites of injury (Kinavey and Cool 2019) in these stories include surgical rooms, chiropractic offices, the waiting room of OBGYN centers, inside emergency rooms, and many other spaces.

Assumptions about the fat, health-seeking body

Fat people cannot currently move through this world without assumptions being violently flung at our flesh. Although many assume medical objectivity exists, it is pertinent to recognize that anti-fat bias infiltrates health care spaces, too. All my participants had a story, if not multiple stories, related to health care providers making negative assumptions about their bodies, their food intake, their exercise routines, and their overall health statuses. Lynn and Bianca explicitly shared with me that they believe it is more likely for doctors to treat their fat patients based on their own assumptions, than it is for them to provide non-judgmental and appropriate care. Although this is an opinion of my participants, it is also backed by empirical evidence (see Ferrante et al. 2010; Phelan et al. 2015). Medical professionals have been found to have their own anti-fat bias impact the health care they deliver to their fat patients (Phelan et al. 2015). In fact, research has shown that health care workers view appointments with fat patients as a waste of time because they assume that fat patients do not care about their health and will not follow medical instructions (Ferrante et al. 2010).

An early prompt that I asked my participants was to tell me how they felt fat people were treated in the U.S. Almost all of them expressed that fat people are treated as if our corpulence fundamentally deems us unhealthy. This notion seems to be held by most of the U.S. population. Moreover, this idea, along with other colonial, racist, sexist, ableist, and other discriminatory ideas, is ingrained in much of mainstream health care and absolutely informs the medical gaze. For example, the first story Caroline told me was about a specific doctor's appointment. Though she can no longer remember the actual purpose for the appointment anymore, she does remember one of the statements her doctor made to her. In the middle of the visit, and seemingly out of the blue, her doctor said, "Don't eat the whole box of cookies. Just eat one cookie." From Caroline's

memory they were not discussing her diagnosed eating disorder, food intake, or any other topic that would connect health status to food consumption. Caroline's story is an unfortunately perfect example of the medical gaze in motion. The medical gaze strips the patient's humanity away. This doctor did not need to ask Caroline about her cookie consumption, or lack thereof. Instead, his medical gaze informed him enough; her body spoke for itself. In his examination of her pathologized and deviant body, he reduced Caroline to her corpulence. This is proof enough, under his gaze, of overeating. While this interaction baffled Caroline, for her doctor, this was an easy outcome of his presumptuous assessment.

My participants revealed a fascinating and disturbing phenomenon to me. In my interviews with them, I heard many stories of doctors and other medical staff assuming that these women did not know that they were fat. Some described it as if they had suddenly woken up fat that very morning. I expand on this story later, but an example of this interaction occurred between a White participant, Patricia, and a weight loss surgeon. During their surgical consultation, Patricia directly asked the surgeon if he thought she should receive this surgery. He went through multiple reasons as to why she should get the surgery, centering social status and stigma management justifications. One of his reasons was this, "I don't know if you realize this," he began, "but people look at you differently in the world because of your body and because of your weight. You face discrimination and all of that would change. Your life would totally change in the way people see you [if you got the surgery]." This comment insinuates two main ideas. First, this surgeon finds it completely appropriate to offer medical advice based on social perceptions. Though the decision to seek cosmetic surgery is one of personal and has been found to be connected to social perceptions (Locatelli et al. 2017), it is important to understand that weight loss surgeries such as gastric bypass are not considered cosmetic surgical procedures

(Penn Medicine Princeton Health 2021). Therefore, social reasonings should not necessitate a medical surgical procedure. Second, this surgeon suggests that Patricia is oblivious to the anti-fat discrimination that she faces daily as a fat woman. He seems to assume Patricia is too inept to realize the social treatment she faces or too lazy to care, neither of which are true.

Some participants were clearly annoyed and exhausted with how often they experienced this assumption. As if talking directly to her doctor, Heidi said in our interview, “Fat people know that they are fat. That is not new. I know sometimes you [health care system and workers] think that like, that’s important say, but we know.” Similarly, Amy heatedly said to me, “No matter what, they’re going to look at me and say ‘Hey, did you know that you’re fat?’” May also commented on this phenomenon. Dripping in exhaustion, frustration, and sarcasm she said to me, “I woke up fat this morning and I had no idea! As if they’re the first person who has ever said anything [like that] before.” May’s comment specifically inspired me to call this phenomenon “woke up fat.”

Health care workers act as if fat people don’t understand the bodies we live in, how they function, and how they’re socially perceived. For instance, Ella shared an experience with me from when she was 13 years old. She was visiting some family and developed an ear infection. To treat the infection, Ella’s cousin took her to a nearby clinic. As with most medical visits, the appointment began with Ella being asked to step on the scale. After comparing her weight as indicated by the scale to the size of her body, the clinic staff told her there was no way she could actually weigh that much. When Ella took a look at the scale, she confirmed that this was her normal weight. Still, the staff did not believe this was the case. Because of their assumptions about her body’s shape, the doctor and nurses could not fathom the possibility that Ella could truly weigh what the scale was insisting. Before choosing to believe a patient about her own

body, the health clinic staff went on a righteous crusade to prove the ineffectiveness of the scale. In fact, they had a few other clinic employees step on the scale to test the tool's accuracy. After multiple individuals, including teen Ella once more, confirmed their weight on the scale, they finally moved on with the appointment. These medical staff members acted as if Ella's knowledge was inaccurate and inferior. Because fat people are assumed to be lazy and unintelligent, we aren't considered to be experts on anything, let alone our own bodies.

Samantha Murray (2008) encourages us to recognize that medical objectivity is a cultural fiction. Accordingly, health care staff hold preconceived social assumptions and biases that they, intentionally or not, may apply to their patients. The stories shared above were certainly connected to social perceptions, but ultimately were rooted in ideas of health and the ideal healthy body. Health care staff have also demonstrated their understanding of fat people's social status. For example, Maddy told me a story of how she was a sexually active teenager seeking to prevent unintended pregnancy. She went to the OBGYN to obtain birth control. When her doctor asked her why she was interested in starting birth control, she simply responded that she was having sex and didn't want a child at this point in her life. Though this experience happened over a decade ago, Maddy can remember the sheer look of confusion her doctor had on his face. This confusion transformed into a slightly appalled realization. As Maddy described to me, "The realization that a fat person could be having sex was like, visibly happening on his face." The insidiousness of anti-fat assumptions and bias is that these exist within nearly all institutional contexts in the U.S.

Fat stigma results in tangible suffering

The assumptions described above are all founded upon anti-fat bias and fat stigma. Weight-based assumptions coupled with anti-fat bias can lead health care workers to embarrass,

dehumanize, and physically harm their fat patients. According to my participants and as demonstrated in a few of their stories already, it often feels like their doctors' assumptions about my participants' fatness took precedence over their own perceptions of their conditions, symptoms, and health status. Experiences like these can leave fat patients feeling invalidated, unheard, and uncertain about reality of their own perspectives. Medical anthropologist, Norma Ware (1992) refers to the systematic trivialization and disconfirmation of one's perceptions and definitions of illness as *delegitimization*. Ware (1992) explores delegitimization as it is experienced by those who have chronic fatigue syndrome. In her qualitative study, she found 90% of her sample experienced two primary forms of delegitimization. First, there was the trivializing of this condition's symptoms. This happened both within and outside of medical contexts. According to Ware (1992), chronic fatigue syndrome symptoms are often dismissed as things that everyone experiences. Second, there was the overwhelming disbelief that these people were even sick at all. Ware (1992) described how her participants were often not being believed by medical authorities, among others, about their illness and being convinced it's "all in their head." Ultimately, delegitimization occurs because the medical gaze does not see these patients as sick *enough*.

The connection between the delegitimization of patients with chronic illnesses and fat patients is not exact, nor are these necessarily separate populations. Instead, there is this paradoxical similar, yet oppositional relationship between the two. Where delegitimization as described by Ware (1992) leads to the making of symptoms so insignificant that the patient is deemed not sick, delegitimization for fat people is the exaggeration of fatness as their primary

symptom of illness⁷. Fatness is treated nearly as a null and void in terms of the ability to be sick outside of the corpulence, or any experiences of sickness becomes the result of being fat. Though one can argue that any medical patient is rarely viewed or treated as an expert of their own bodies, my participants have unveiled that there is a uniqueness to the delegitimation of fat women's bodily knowledge.

While concern over health status has been used to justify the harsh discrimination directed toward fat people, this justification is ironic as recent research has suggested that fat stigma is a determinant of weight gain and poor health status (Tomiyama, Carr, Granberg, Major, Robinson, Sutin, and Brewist 2018). Fat stigma does not merely decrease one's health, but also one's overall wellbeing. A third of my participants shared stories with me that demonstrate how medically facilitated stigmatization and anti-fat bias-influenced treatment result in tangible suffering and contribute to a lower quality of life.

Many women told me about not having their symptoms taken seriously and being made to wait for a diagnosis. For example, less than a year ago, Roxy was diagnosed with tachycardia. This is defined as a fast heart rate that is out of the norm for an individual's age and/or activity-level (Awtry, Jeon, and Ware 2006). She was diagnosed after going to the emergency room and finding out her heart rate was 180 beats per minutes at rest. Although Roxy did eventually receive a diagnosis, she told me in frustration how she had gone to multiple doctors over the last five years with concerns about her heart rate. Each time she would bring up her concern, she was brushed off in some way. She said, "I was having uncontrolled arrhythmia of my heart that was not taken serious, so that's discouraging." Some doctors told her she was just experiencing

⁷ To be clear, this is not to insinuate that fatness is a health condition, as most health care professionals might call it. Instead, this is to recognize that fatness is pathologized, and therefore treated as an illness.

anxiety or a panic attack. Other doctors told her she was just out of shape. Roxy attributes the prolonging of this diagnosis to these doctors' perpetuation of fat stigma. She said:

I am in a fat body. I am in a female body. I have a diagnosed mental health condition that, again, although well-managed, if anyone has an unconscious bias where they assume that in some way makes me less reliable or less capable for judging things. And so, I mention that because I have had many instances, and I suspect many women have and many fat people have, of not having my symptoms taken seriously...Or of being assumed to be just the result of being in a fat body...Or that I am overstating symptoms due to anxiety in some way. And that has often required me to not only be my own advocate, but in many cases, my own diagnostician and doing research on my own to identify what I am dealing with.

Bianca, a bisexual White woman with chronic stomach pain, shared similar thoughts and experiences. For a large part of Bianca's life, she has struggled with chronic stomach pain and difficulty digesting food. Although she has gone to multiple doctors for this issue, no one has been able to diagnose her condition. Because of this, Bianca has not only had to advocate for herself to have certain tests, but she's also had to come up with her own treatment plan. She told me, "I just kind of suffered with it because doctors didn't really do anything to take it seriously." There was not a single doctor who could provide her with advice aside from eating more fiber and trying to lose some weight. "No one was really concerned about how much pain I was in," Bianca shared. "This hurts me, like every single day to the point where I can't really eat anything." Because of the lack of earnest attempts at helping her with this issue, Bianca couldn't help but assume her doctor's and specialists were thinking, "Oh, it's making it so you can't eat? Good." Here we see a delegitimation (Ware 1992) of Bianca's bodily knowledge and symptoms.

The stories I've highlighted in this section have unveiled the double burden of being fat and a being a woman who is seeking health care. This isn't to say that being fat or a woman is inherently burdensome. Rather it is the systems that purposefully target and inflict violence on these individuals is what's burdensome. More than burdensome, these systems are life-

threatening instead of life-affirming. Furthermore, and due to the lack in diversity of this sample, this study does not fully address or explore the delegitimization of fat patients' knowledge who also hold other marginalized identities such as being physically or visibly disabled, being transgender and nonbinary, or being an immigrant.

Though my participants' experiences have revealed that it is not uncommon to go without diagnosis for years if not for the rest of one's life, neither Roxy nor Bianca were explicitly confronted with aggressive, anti-fat discourse such as what Amy had to manage. A few years ago, Amy was in a car accident. Though she survived, she was left with a myriad of health complications. While seeking treatment and support, Amy was denied both a proper diagnosis and appropriate treatment because of her doctor's perception of her weight. After having written her own case management notes and presenting the details of her current symptoms, she said, "He [her doctor] just looked at my blood pressure and he said, 'Look. You're fat. You're overweight. You don't work out. You're crazy. There's nothing wrong with you.' He decided in his head that I was fat and that's all that was wrong." Ultimately, it took her three years before she received a diagnosis for a concussion that resulted from the car accident.

When I asked about her health care experiences, May shared one of her most negative encounters with me. At one point, May was the patient of a dietician who worked in a bariatric surgery practice. As her patient, May said "[the treatment was] wrong on a personal level, but it's also wrong in a medical level." She did not believe the dietician was giving her medically-sound advice because she was trying to get May to eat a 600-800 calorie diet in order to get her to lose weight to qualify for surgery. As May described it, this was essentially a starvation tactic intended for her to drop weight. In addition to this extreme calorie-reduction, May's dietician expected her to keep a food log and would give her suggestions on how to decrease her calorie

intake each week. Since then, May has switched dieticians and now is the patient of one who validated that the care May received was inappropriate and harmful. During the interview, she reflected on her time as a patient at this center and said, “It was pretty horrific. I was in tears every time I was inside there.”

Having been diagnosed with polycystic ovarian syndrome was a common experience among the individuals interviewed for this thesis. As mentioned earlier, PCOS is a hormonal disorder that causes a variety of symptoms including the enlarging of ovaries and development of cysts within the ovaries, menstrual irregularity, excess hair growth, acne, and weight gain (ACOG 2020). Maddy was one participant who mentioned being diagnosed with PCOS. This diagnosis was recent, and the progression of this disorder for Maddy was made worse by the inadequate care provided by her doctors. Maddy was on birth control consistently from age 14 until around the age of 22. Once she stopped taking birth control, Maddy ceased menstruating. Though a change in menstruation is a common symptom of PCOS, no matter the person’s body size, Maddy’s primary care physician outright told her that PCOS happens when people are fat and thus, Maddy should intentionally lose weight in order to manage her diagnosis. Maddy, now 35 and having been off birth control for over a decade, attended an appointment with a new OBGYN who was shocked by her story. This new doctor informed her that she should’ve never been allowed to go that many years without a menstrual cycle because it increases the risk of ovarian cancer substantially. Maddy expressed her frustration around having this diagnosis and only receiving weight loss as a treatment plan. Maddy said, “She did increase my chances for cancer quite significantly. That’s a tangible result of the over-emphasis of fatness that happens in medical settings.”

Weight loss as treatment and barrier

Scholars have argued that health care providers over-attribute symptoms and conditions to one's weight (Malterud and Ulriksen 2011; Phelan et al. 2015). Researchers have also suggested that intentional weight loss advice during health care appointments can squander a patient's time, effort, and resources (Tomiyama et al. 2016). Despite this, medical personnel are still more likely to suggest weight loss advice to their fat patients than they are to explore other treatment options (Halbert et al. 2017; Meerai 2019; Murray 2008). Furthermore, they are more likely to blame fat patient's weight on other medical conditions than they are to assess the environmental factors that are contributing to a patient's health status such as stressful life events, interpersonal difficulties, and socioeconomic status (See: Meerai 2019). The most common pattern found within negative health care experiences by far, as described by my research participants, was having weight loss regarded as either the primary treatment for their medical conditions or a barrier to treatment for these conditions. This was alluded to in the section above, but here I focus more specifically on these moments where care is delivered as diet advice, weight loss surgery recommendations, or outright treatment denial until weight loss.

The frequency with which weight loss advice is emphasized as treatment itself, or as a barrier to treatment was such an integral part of why these women felt so compelled to over-prepare for their health care appointments. My participants had many first- and second-hand stories to share with me. For example, Patricia told me that while she was in college, she came down with a particularly severe sinus infection. When seeking treatment from the health care staff at her university health clinic, Patricia was shocked to be receiving weight loss recommendations instead of sinus infection treatment. She said, "I was sick as a dog and she [the doctor] wouldn't prescribe me any antibiotics, and she wanted to talk about weight loss." This

was not the only story Patricia told me where she or someone she knew was denied appropriate care due to a medical authority's perception of weight on the body. She also told me about her cousin who was denied gall bladder removal surgery until he lost weight. By the time her cousin sought surgery, he had already unintentionally lost 40 pounds due to his inability to eat or keep food down. Essentially, Patricia's cousin's weight loss was prioritized over the removal of a painfully malfunctioning organ.

Nearly all my participants shared stories such as these. However, as both a researcher and a fat person, there are stories from three White participants, Caroline, Maddy, and Patricia, that I feel most compelled to share. These stories underscore the tangible suffering that occurs when health care professionals use weight loss as a barrier for obtaining necessary medical treatment, as a goal amid an already-risky condition, and as a solution to social stigmatization.

At the time of our interview Caroline had recently experienced an umbilical hernia. She explained to me that she had undergone urgent repair surgery after the hernia became infected. Due to said infection, her ER surgeon was only able to partially repair the site. He informed her that this was a temporary fix and that she was likely to re-herniate within that next year. The surgeon was right, and Caroline was back in the ER within four months of the emergency surgery.

Although the ER surgeon was the same as before, there were two large differences between this meeting and the last. First, Caroline no longer had an infection at the site of the hernia. Thus, she assumed she'd be able to receive the more permanent surgery that involved an internal supportive patch. The second difference, and one that caused a lot of frustration for Caroline, was that the surgeon would not schedule the procedure until Caroline went on a diet and lost weight. Caroline seethed in anger and told me, "I was floored. I was so stunned. I

couldn't even say, 'Why didn't you tell me this four months ago? That's not what you said four months ago? You didn't even mention my weight four months ago, but now you're denying me care because I'm too big?'" Caroline explained her history with diets, having lost over 100 pounds twice in her lifetime just to gain all that weight back and then some. However, according to Caroline, the surgeon did not listen to her. Instead, he continued to necessitate a decrease in weight before he would perform this surgery Caroline eventually did find a surgeon who highly recommended that she receives this surgery now, instead of post-weight loss. For Caroline, this was evidence that the ER surgeon's anti-fat bias prevented him from providing appropriate care.

Some participants described being given different treatment than the known best practices for their conditions. They attributed this differential treatment to their doctor's negative perception of fatness. Maddy told me about a health care experience that not only involved her own life and wellbeing, but the lives and wellbeing of her children. Much of my interview with her was spent discussing her treatment throughout her very risky pregnancy.

After some obstacles with conceiving, Maddy and her partner found out they were having twins. Maddy shared with me that, in general, twin pregnancies come with their own set of risks. However, this risk was amplified when her babies developed a syndrome in the womb that could have put all of their lives at risk if not monitored. Because she was dealing with such a high-risk pregnancy, Maddy was receiving care in a large hospital facility from a team of doctors. To understand what was happening and because she is a researcher herself, Maddy studied the efficacy of certain treatment plans associated with this condition. Much of the current research on this condition identified bedrest as necessary part of treatment. However, Maddy was explicitly denied bedrest by one of the doctors on her team. Furthermore, this doctor not only

encouraged, but nearly demanded her to exercise throughout her pregnancy. This actively went against the known best practices for treating pregnant women with this condition.

At one point in our interview, Maddy and I discussed the uncertainty in experiencing fatphobia. As Maddy said, it is not always clear if someone's behavior and demeanor is guided by fatphobic intentions. However, in this case, Maddy believes that her doctor treated her this way because she is a fat woman. In a post-partum consultation with the doctor who denied Maddy bedrest, he bluntly told her that he did not believe her body was currently equipped to sustain any future pregnancies due to her size. This has since made Maddy question if most of the decisions he was making throughout her pregnancy were with an anti-fat agenda in mind, conscious or otherwise.

As demonstrated previously, the problem with fatness has very little to do with one's health status. No story makes this clearer than what Patricia shared with me in our interview. Earlier in life, Patricia used to be someone who would buy into diet culture with her mind, body, soul, and wallet. What changed this was, interestingly, a consultation with a weight loss surgeon.

At one point, Patricia was seriously considering scheduling weight loss surgery. To better understand the surgery and to determine if this was really the right path for her, Patricia attended an educational seminar on the procedure. At this seminar, the surgeon who would be conducting the procedure got on stage and said to everyone, "I know you all get blamed for your size of your bodies and your weight." He followed, "But I know you're not the people that are sitting around eating a whole bucket of chicken by yourselves each night [because] research shows that people in bigger bodies are the ones who eat better than other people, especially when you go out." Patricia explained how this surgeon described the social stigmatization of fat bodies and how

weight loss surgery is the closest thing to permanent weight loss that the medical industry has developed thus far.

Days after the seminar, Patricia met with the same doctor for a one-on-one consultation. At this session, she bluntly asked him “Do you think I need the surgery?” After she gave him her medical records, the surgeon looked at Patricia and told her, “Well, you’re beautiful. You’re smart. You’re successful. You’re healthy, but...what if in the future you’re going to develop diabetes? So, that’s one thing. We don’t know if your health is going to stay good.” He followed this with, “Also, there’s probably some things in your life that you can’t do, like skydiving or maybe hiking is difficult for you. This [surgery] would make it a lot easier. You could do anything you want!” Then he said, “And I don’t know if you realize this, but people look at you differently in the world because of your body and because of your weight. You face discrimination and all of that would change. Your life would totally change in the way people see you.” Patricia thought to herself, “So you’re telling me to cut out my stomach so that people will treat me better? He’s giving me all of these reasons for cutting out my stomach, none of them have to do with health.” Patricia’s story provides evidence for a new category of surgical procedure. Weight loss surgery, as described by the surgeon above, is not quite medically necessitated, nor all the way about one’s health status. It’s certainly not a cosmetic surgery, either. Instead, his argument to Patricia creates something we might call a “social surgery” or even “stigma management surgery,” where one obtains a surgical procedure to subvert the negative social meaning ascribed to their body.

One of the most common themes in my participants’ interviews with me was that the feeling that health care employees viewed them as one-dimensional. It appears fat patients’ body sizes overshadow any other condition they might be dealing with, in the eyes of health care staff.

For my participants, it was rare for their symptoms and conditions to be fully explored on their own, without being linked to their weight in some way. A White participant, Joy said, “It’s dehumanizing to get reduced to one single problem that isn’t actually helping any of my problems health care workers cannot differentiate between obesity as a pathological disease and the person existing in the fat body.”

Qualities of the Rare Positive Visit

Though each of my participants could describe at least one, if not many more, negative aspects of their health care encounters, the same was not true for their positive experiences. In fact, Anne outright denied having ever experienced any positive appointments. She said, “I wouldn’t say I’ve ever experienced a 100% positive experience. There is always *something*.” Whether it was a look, a comment, or inaccessible equipment and furniture, many of these women could name some component that prevented them from having an overall positive health care experience. Though my participants provided more insight into negative health care visits, some still shared good parts of their visits. When asking Ella about her perspective on positive appointments she said, “I mean, nothing I can really think of where I can say, “Oh wow! That was *amazing!*” However, she followed up by describing the pieces of positivity in her health care appointments.

Through careful analysis, I found three central components of positive appointments for my participants. This section is set up so to individually evaluate each component. The first of these includes having one’s humanity recognized in health care settings. Here I describe my participants’ perspectives on being listened to, given time with their doctor, and having their knowledge and decision-making treated as legitimate. Another component of visits that was just as surprising as it was positive was the lack of weight-based conversations when unprompted.

Two-thirds of my participants shared how good it felt for them to attend health care appointments that did not involve intentional weight loss as a treatment or to not receive negative and presumptuous comments about their activity levels and food intake. The final component was the ability to gain access to appropriate diagnoses, medicines, and treatment plans was a strongly emphasized as a positive component of health care visits.

Sense of Humanity

A few participants mentioned the positivity and strength they felt when they were given the opportunity to make collaborative decisions around their health care treatment. For example, Layla's first appointment after a few years without a doctor's visit was "super positive." One reason for the appointment was to discuss managing Layla's polycystic ovarian syndrome (PCOS). After she expressed her desired treatment plan, her doctor agreed to support her managing this plan for the next year together. She said, "being able to just, like negotiate that" was what made the appointment so good. Essentially, Layla's doctor validated, rather than delegitimized, her knowledge as a fat, multiracial Black woman— an unfortunately rare occurrence. In addition to the ability to work collaboratively with their health care providers, some participants found it positive when being able to decline services or treatment. Both Heidi and May mentioned the sense of strength they derived from being able to refuse being weighed or seeing their weight in their patient charts.

There is evidence that doctors and nurses view and treat appointments with fat patients as a waste of their time (Bleich, Pickett-Blakely, and Cooper 2011; Ferrante et al. 2010; Hebl and Xu 2001). Knowing this can give us context for why my participants find having more time with their health care providers as a positive, humanizing experience. Bianca told me, "It's sad to say that with what makes a good doctor's [appointment] experience is them actually giving you the

time of day but, like, that's kind of what it feels like.” Bianca’s current primary care provider has been her favorite doctor that has ever treated her. There are a few reasons for this, one of which being the time she gives to Bianca each appointment. She said, “She’s [Bianca’s doctor] not trying to rush me out of the room as soon as she can to get to her next patient.” Where Bianca focused on receiving time to discuss her conditions, Anne expanded upon the idea of being offered time with her doctors. She said, a good doctor is someone who “lets me talk [and] lets me explain what’s going on without cutting me off constantly.” Anne understands time not only as the minutes spent with a doctor, but how often she was given an opportunity to speak. There is no denying that many health care patients are not always given a satisfactory amount of time with their primary care physicians. However, there is empirical evidence that has shown doctors spend one-fourth less of time with their fat patients than they do their nonfat patients (Hebl and Xu 2001).

Rarely does medical discourse affirm the lives of fat people. Therefore, the moments when fat people are made to feel human, to feel cared for as a person, rather than as a fat body, are profound. As mentioned earlier, Caroline has undergone numerous anesthetic procedures as of late. Although she has a lot of fear around these procedures, she also had one of the most life-affirming experiences connected to this type of procedure. She told me:

One of the most powerful experiences I’ve had was undergoing another anesthetic procedure and there was this anesthesiologist...Actually, I never got a glimpse of him before I shut my eyes. But he...He had me place my hands over my torso and crossed my arms. He put his hands on mine and he was like, ‘It’s okay. You’re good. This is going to be okay. You’re going to do well.’ And it was incredible. I was a person in this moment to this guy. I wasn’t the large body on a slab. You know? It was so profound to be felt and seen as a person, a worthy person on that table. It was a saving experience.

Interacting with a sensitive primary care provider was positive for my research participants. For instance, May shared that she finds it positive when doctors approach her body

with a sense of curiosity. She wants to see a willingness to learn from the health care workers she interacts with. May elaborated on this by saying “[Health care providers] wanting to know how I perceive my body and what I want from my body...People who are sensitive to my feelings.” It does not appear that many of my participants have engaged with sensitive care providers. Five of my participants have been diagnosed with an eating disorder at some point in their lifetimes. Many of them were in remission at the point of our interview. Of these five, only one of them mentioned having a doctor who was concerned about the appropriateness of certain topics with those diagnosed with an eating disorder. Heidi told me how her doctor would give her the option to opt out of conversations. She said, “She’d [Heidi’s doctor] be like, ‘Well, you know, I want to talk about *this*, but we’re not going to talk about it unless you think that’s a good idea.’ And I’d either be like ‘yes or no’ based on my feeling at that time.”

(Lack Of) Stigmatizing, Weighty Conversations

My participants indicated that recommendations for intentional weight loss treatments were normal at nearly any health care appointment, including those that had little-to-nothing to do with their weight. Thus, many of my participants mentioned how surprising it was when they either did not have their weight brought up, receive weight loss advice, or if they had their weight discussed in a more objective manner. Nearly half (46%) of my participants considered their appointment positive if none of the health employees they interacted with brought up their weight. “If they don’t bring up my weight,” Bianca said, “that’s a win!” Even more positive were the rare moments when participants received nonjudgmental, non-weight-based, life affirming care. For example, Roxy was shocked to work with a dietician who encouraged her to eat more food rather than continue in her food-restricting lifestyle. The dietician was not concerned with Roxy’s weight, rather she focused on Roxy putting the correct nutrients in her body.

Additionally, both Maddy and Stacy considered their appointments positive when they were not blamed or shamed for their weight or health conditions.

Weight-based conversations in health care settings are viewed by some fat people as stigmatizing (Paine 2021). However, this is not because one's body weight itself is inherently stigmatizing. Rather, it is the negative social implications of what it means to exist in a fat body that creates the stigma. This explains why some of my participants welcomed conversations about their weight. A few participants found it useful when their health care provider could address their weight in an objective manner. I have mentioned that objectivity is impossible to perform as a researcher; the same is true for health care workers. However, my participants seem to have constructed an agreed upon definition of objectivity. This includes using their weight as a health metric, rather than a moral failing. Layla, for example, attended a health appointment where she and her doctor discussed the relatively recent weight gain around her midsection. "The fact that I'm gaining weight around my midsection is an indication that my insulin resistance is not being managed," she said. Layla followed with, "It was nice to have a conversation about weight within the context of my own health needs, instead of a blanket statement: you're fat; lose some weight."

Gaining Access

When I asked a White participant, Martie, about what made her health care appointments positive, she shared, "I feel positiveness from asking for what I need and getting it." Fat women are more likely to receive inadequate health care treatment that leads to negative repercussions on one's health status than non-fat women (Cohen et al. 2007; Mitchell et al. 2008; Aldrich and Hackley 2010). Despite researchers arguing that health care providers offering their patients intentional weight loss recommendations could be a misuse of fat patient's time (Tomiyama et

al. 2016), their advice to fat patients continues to push an anti-fat agenda. Furthermore, my participants have shared stories of being denied access to certain medical interventions merely because of their weight. Therefore, just over half of my participants identified gaining access to appropriate, non-weight loss centered treatment, medicine, and diagnoses was something that they found positive about their appointments. Patricia said, “It was just such a relief to get treatment for the issue and the treatment plan not be ‘lose weight’.”

Each of my participants have shared that they care about their health status. Thus, there is a sense of positivity that comes from normalizing the symptoms of their conditions, obtaining a diagnosis for a condition, and receiving life-affirming health care. Furthermore, a few participants were appreciative of being taught tangible skills that improved their health status. For example, Roxy is a White woman and mom of two children who had been diagnosed with an eating disorder. When she sought treatment, she hesitantly met with a dietician. Roxy assumed working with a dietician was going to be harmful. However, this dietician ended up being one of Roxy’s biggest supporters in healing from her eating disorder. This dietician taught Roxy how to appropriately nourish her body and unveiled to Roxy that restricting food intake does not promote a healthy relationship with food or with her own body. “The thing that I think is most fascinating,” Roxy shared, “is the less I restrict, the less I binge. I don’t binge anymore. I have no symptoms of a binge eating disorder at this time.”

This section demonstrates that fat women do experience positive health care appointments, or at least positive components. However, they are not as frequent as negative and stigmatizing visits. When I asked my participants about negative health care experiences, many of them disclosed stories of trauma, frustration, and discrimination. When I asked them about positive health care experiences, I had descriptions and qualities shared with me. For example,

instead of being told a story of a positive experience with a health care provider, I was told things like “it is positive when a doctor listens to me” or “it is positive when there is a chair that fits me.” It seems as though it was easier for my participants to describe what *could* make their appointments positive, rather than sharing lived experiences with me. Based on my data, I believe this is due to the looming threat of stigmatization that comes with each appointment. “It’s hard, even if it’s positive,” Caroline shared, “it’s still hard to know that this [health care system] could be easier on me if my body was smaller.”

Following Health Care: Feelings & Actions

There is a dearth in information about how fat patients cope with stigmatizing health care appointments after they occur. Thus, this research sought to begin filling this research gap. Over half of these participants did not report having any sort of regular post-appointment process. These participants described going right back to work, diving back into schoolwork, or having to take care of their families at the conclusion of their appointments. May said, “I think I usually just kind of jump right back into my life. If I have to compartmentalize to get through whatever I need to get through, then I compartmentalize...which is not the healthiest response I have, but it [gets] the job done.” In a similar vein, Heidi mentioned that nothing has been terrible enough for her to have to do any sort of self-care after appointments. She did mention that if she experienced a tough appointment that she might be gentler with herself throughout the day but did not categorize this as a consistent routine. While she could thoroughly describe the anxiety and fear she felt as she prepared for her appointment, Layla also spoke to her lack of awareness around how appointments influence her once they conclude.

Though there was some overlap between the different post-appointment routines, interactions, and behaviors, this was only slight. Some interviewees mentioned various forms of

self-care such eating meals, acquiring treats, and making sure to not schedule anything after an appointment. For example, Lynn said that she would usually schedule her appointments in the morning. Therefore, her post-appointment routine typically included breakfast or brunch, depending on the precise time of day. Joy also told me how she would treat herself to a Starbuck's drink after her visits. As she waits in the drive-thru line, Joy reminds herself, "You endured something." A few participants mentioned journaling to help alleviate the feelings from the visit. A quarter of participants mentioned discussing their emotions surrounding their health care visits with their therapists.

Many of the participants expressed how conversations with health care providers about weight and food consumption were oftentimes not consensual or trauma informed. Over a quarter of my participants have diagnosed eating disorders. When medical authorities do not take conversations around weight with sensitivity, they're causing harm to their patients. For instance, both Roxy and Bianca spoke to how their relationship with food is altered after particularly negative and weight-centered appointments. Roxy said, "I have to work harder not to binge after I have a conversation with a doctor who is critical about my body size." Bianca had similar things to say. She emphasized how some appointments will negatively color the rest of her evening and reignite her body image issues. She said, "There have been times where I will go to the doctor and have a bad experience and then it, it makes me feel like I shouldn't be eating something for dinner."

Nearly a quarter of participants described crying after their appointments. Patricia specifically said it didn't matter if the appointment was positive or negative, crying was merely part of her post-appointment routine. I used the phrase routine here because Patricia described crying as a regular occurrence after nearly all of her appointments. Similar to how participants

felt when it came to preparing for appointments, some participants felt the way they went about their day following their health-related appointments was dependent upon the mood and type of appointment they just experienced. For example, Stacy mentioned that for positive visits, she could usually go about her day afterward. For health care encounters that were negative, she mentioned how she would call her sister to process.

Anne was very upfront about the emotional turmoil she feels around health-related appointments. She described how relieved she would feel to have an appointment be over. This relief was followed by tears and sometimes even dissociation. She said to me, “It’s [health-related appointments] not like a quick thing to get over and sometimes you have to get over it because that may be your only choice to deal with your situation. You know, you have to put up with this mistreatment just to get any progress on your condition.” She also described how the COVID-19 pandemic impacted her post-appointment routine. She explained to me that pre-pandemic, she would usually have to return to her office job immediately following any doctor’s visit. Since then and as COVID-19 pandemic protocols have reshaped our lives, Anne finds herself having a more flexible schedule after any of her appointments. She said, “I’ve been able to make more time for myself, because I don’t have to rush back [to work].” Though Anne seems to appreciate having more time to intentionally take care of herself, she acknowledges that this has done little to change her drive to advocate for herself. More on these women’s perception of self-advocacy in the following chapter.

Over half of my participants commented that they rely on community to process their experiences. by. For a few, they relied on their own friends and family members. Martie, Amy, Roxy, Stacy, and Layla all mentioned bringing someone with them to process their appointments with or having a post-visit call with a trusted loved one. Even more participants relied on online

community support, particularly that of fat-positive community support. Very few participants mention creating any of their own posts in these groups. Instead, many of them would merely read and like others' posts. As Stacy said, "I don't usually post, but I enjoy reading about everybody else's experiences. I get support vicariously through hearing what everyone else is going through and their victories." Although participants were not expected to describe the body size of anyone they relied on for support, a few mentioned that they relied specifically on their fat friends and family. As Heidi said, "fat people understand that fat people are oppressed." In opposition, non-fat people tend to have less of an understanding around the lived experiences of fat people.

CHAPTER VI: CONCLUSION

The purpose of this research was to explore and unveil the stigmatization that fat people experience in health care settings, as well as uncovering how fat patients cope with these stigmatizing experiences. Though there is quite a lot of literature about *obesity* and medicine, my study challenges much of this research by asking fat people, themselves, about their health care experiences. This research positions fat people as experts of their own lives and bodily experiences. Though I had many questions cropping up throughout this research process, I kept within the borders of three main questions. First, how do fat patients prepare for health care appointments? Second, how does the U.S. health care system and medical institution reproduce and perpetuate stigmatization of fat patients? Lastly, how do fat people understand their experiences of stigmatization that come from the hands of medical authorities and how do they manage these experiences? With these questions in mind, I collected and analyzed health care-related stories from 15 self-identified fat women in the U.S.

Throughout February and March of 2021, I collected my data using the qualitative method of semi-structured, in-depth interviews. Because of the COVID-19 pandemic, all interviews were done through video conferencing or phone calls. These conversations lasted between forty-five and ninety-minutes. While I created an interview-guide, I encouraged participants to lead the interview with whatever they wanted to share with me. Following the completion of all interviews, I utilized Webex to produce the initial copy of the transcriptions. Then, I reviewed the transcriptions and began an open coding analysis.

In this thesis, I have presented what health care looks and feels like for fat women in the U.S., in particular for fat, White women due to sample make-up. However, I did not just start and end here. Instead, I felt compelled to build context as to the social meaning of fatness and fat

stigma. Thus, I began this study by obtaining my participants' perspectives on fatness and health, broadly. I explored these perspectives throughout Chapter IV of this written work.

I found that my participants used a lot of words to describe their bodies such as “big” or “chubby.” Nevertheless, “fat” was the most used and preferred word by far. When I asked these women why they called themselves “fat” and how they defined this, two primary themes emerged. First, to be fat is to live in a body that is larger than the societal standards deemed appropriate or normal. Throughout this thesis, I have pointed out ways that the fat body is otherized, interiorized, and viewed as a threat to the ideal, disciplined body. The second theme was that the word “fat” is neutral. Many participants agreed that fatness is merely the reality of their body, without any morality connected to it. Ultimately, my participants convey to me that there is nothing hidden when calling a fat body *fat*.

Through my analysis, I found an interesting paradox of how fat people exist in the social world. To be fat in the U.S. is to be both invisible and hypervisible. The fat body is so socially stigmatized and physically detectable that it often overshadows all other aspects of the person existing in the fat body. More than this, the fat body is deemed non-normative, and therefore less deserving of consideration. Thus, fat people exist between the seemingly hypocritical binary of being both largely ignored and hyper-ridiculed.

My participants challenged the social understanding of what it means to be healthy. Instead of treating one's health status like a binary, either you are health or you're not healthy, my participants understood health to be a spectrum. It is more than the physical presentation of the body. Instead, health status includes physical wellbeing, in addition to mental, emotional, social, and spiritual wellness. There is a complexity to health status it that is often overlooked in both medical and non-medical settings.

Chapter V is where most of my data analysis and interpretations comes forward. There are a few key ideas that I present in this chapter. One of these is that preparation for appointments included behaviors and emotions that aided in the preservation of the *compliant* fat patient (conforming) or demonstrated a sort of *rebellion* against the dominant ideas about fat people (challenging). Importantly, these behaviors were not oppositional or exclusive in that my participants engaged in both conforming and challenging behaviors. The focus of this section was the descriptions of the overarching characteristics, patterns, and impacts of health appointments for fat patients. Though there is a short section on positive appointments, much of the pages in this chapter detail the negative, stigmatizing, and discriminatory qualities of health care visits for fat people. Here, I explore what stigmatization in action and at the hands of health care authorities looks like for fat patients. My participants shared with me how often health care providers used their assumption to guide their treatment, the frequency at which fat patients have weight loss advice give as both the primary treatment for their conditions and a barrier for accessing treatment for their conditions, the environmental components such as furniture, equipment, and clothing that sometimes contributed to a sense of exclusivity in health care settings, and the delegitimization (Ware 1992) of fat patient's own knowledge and perceptions of their bodies, health statuses, and conditions. I conclude Chapter V by addressing what happens after medical and health-related appointments. Interestingly, there was no definitive pattern or common characteristics of post-appointment routines. In fact, over half of my participants did not report having any routine at all.

Theoretical Connections and Research Contributions

The overarching theoretical framework of this thesis is Goffman's (1963) stigma theory. In essence, this theoretical perspective acknowledges that there are certain attributes that socially mark someone as part of normative or deviant groups. This stigma therefore "spoils" one's

identity. The stigmatized individual is made socially responsible for managing their stigma. When the assumptions surrounding fatness are that fat people are ugly, unclean, and unintelligent, it is unsurprising that fat people would attempt to compensate for these attributes—even if they do not hold or express these qualities, themselves. Moreover, when these negative assumptions are believed by health care workers, they impact the care offered to fat patients. As described by my participants and found in other studies, this typically leads to inadequate treatment, discriminatory practices, and stigmatizing situations (Aldrich and Hackley 2010; Forhan and Salas 2013; Phelan et al. 2015; Puhl and Heuer 2010; Tomiyama et al. 2018). Furthermore, these assumptions contribute to the delegitimization (Ware 1992) of fat women’s knowledge and perception of their own conditions. Ware said, “the lack of shared knowledge of the illness [chronic fatigue syndrome] and of meaningful terms in which to describe it made it difficult to argue convincingly for chronic fatigue syndrome as a disease” (1992: 353). A similar, yet distinctly different statement could be made for fat patients. It is the lack of shared knowledge about how fat bodies operate, how illnesses and fatness interact, and how one’s weight may not be the most pressing issue in any given patient’s life that makes it difficult for fat patients to convincingly argue for their own appropriate medical treatment.

Stigmatizing health care and medical experiences have led many of my participants to feel avoidant of health-related appointments or obligated to put up with this treatment and compensate for others’ perceptions of their fatness. Through angry and desperate tears one participant, Lynn, expressed the laboriousness of compensating for one’s stigmatized identity. She said, “It just becomes... it's just a lot of extra work that I have to put in to account for other people's not preparedness to actually serve people like me, and it's so exhausting. Like, every single time I have to go to the doctors.”

Many stigma management strategies are compliance-based and concealing in nature, in that stigmatized individuals work to socially *make-up* for or hide away their stigma. However, this is not true for all stigma management strategies. Some groups and individuals engage in radically rebellious strategies that challenge the normative ideas of stigma and deviance. In my analysis, I found my participant's stigma management strategies had three overarching themes: challenging, conforming, and withdraw. From the beginning of Chapter V when addressing preparation techniques, I reapply the same comparative categories of conforming to or challenging dominant ideas and assumptions about fatness and fat people. Conforming behaviors are those that either confirm or compensate for the dominant ideas and assumptions about fat people. These include types of management strategies that allowed my participants to sometimes appear as compliant patients or position them as healthier than other patients. Challenging behaviors cover the management strategies that demonstrate these women's rebelliousness and humanity. Withdraw is the final category of these stigma management strategy, which does not fall into the conforming or challenging binary. This refers to the health appointment avoidance and delay tactics my participants described to me.

Conforming: Intellectual Compensation, Defensive Othering, & Hiding

A common concern of my participants was appearing incompetent in health care settings merely due to their health care provider's perception of their bodies. As fat people and as women, there is a high likeliness of not having their symptoms or their own perceptions of their health statuses taken seriously. On top of weight and gender discrimination, other participants also experienced stigmatization due to social perceptions and oppressions related to race, class or socioeconomic status, and disability that also contributed to the delegitimization (Ware 1992) of their knowledge. Because many participants assumed they already one strike, if not multiple

strikes, against them, some described engaging in compensatory behaviors. Though none of them used language like this to describe their actions, some of the stigma management strategies were enacted to *make-up* for their fatness. My participants described numerous ways that they avoided being labeled incompetent in health care settings. In line with van Amsterdam and van Eck's research on stigma management strategies used by fat women in their workplaces, my participants explained to me how they compensated in health care settings by showing that "contrary to the constructions produced by healthism and obesity discourses, they were not lazy, dumb, and/or unhealthy" (2019:51). Some may consider these behaviors as challenging, rather than conforming, since they are positioning themselves oppositional to these negative perceptions of what it means to exist in a fat body. However, because of that sense of having to *make-up* for their fatness, there is a, intentional or not, confirmation of the negative assumptions of the fat body.

Intellectual compensation was one of the most common strategies my participants described to me. Described most thoroughly in Chapter V, intellectual compensation was a strategy used by my participants to access adequate health care and construct themselves as compliant patients. My participants described conducting research about their condition and symptoms before their appointment, researching their health care provider's background, and being intentionally articulate to demonstrate their intellectual capacity. Ultimately, intellectual compensation was not merely a stigma management strategy, for my participants, but an overall protective strategy for their own emotional wellbeing and overall health.

In Chapter IV, I outlined *The Fatness Spectrum* framework (referenced in Gordon 2020). This tool has provided language to describe fat bodies outside of the BMI or clothing sizes. Furthermore, *The Fatness Spectrum* aids activists and researchers in conceptualizing the

heterogeneity of the fat community. We know from tools like this, narrative-based evidence, and empirical studies that the larger a person's body, the more likely they are to be discriminated against personally, socially, and systemically. As mentioned earlier, researchers have found that in health care settings the heavier a patient is, the more likely it is that they will receive inadequate care (Ferrante et al. 2010), less time with doctors (Hebl and Xu 2001), and intentional weight loss advice (Halbert et al. 2017). Though all my participants identified as being a fat person and none of them explicitly shared negative beliefs about other fat people, this did not deter some of them from using defensive othering as a stigma management tactic (van Amsterdam and van Eck 2019).

Schwalbe, Godwin, Holden, and Schrock (2000, as cited in van Amsterdam and van Eck 2019) conceptualize defensive othering as a strategy that reproduces power dynamics and dominant ideologies of the stigmatized, rather than resists these things. In short, some of my participants would construct other fat patients as lazier, unhealthier, and more apathetic about their health statuses than that of themselves. Fat people are deemed *worse off* than nonfat people, and very fat people even more worse off. A few participants referenced this defensive othering strategy, but only one participant mentioned actively engaging in it. Ella was unique in this strategy and perspective, compared to my other research participants. Instead of aiming to showcase herself as a good fat patient because of her intellect or through her presentability, she uses a stigma management strategy that she asserts that she is better *by comparison*.

For some participants, concealing parts of themselves in order to present as a compliant patient was how they avoided stigmatization. In essence, these women would hide parts of themselves during their appointments in order to put on a "more presentable" look or demeanor. This does not mean that these women would physical camouflage themselves, although some

women did mention being intentional with their shoe and clothing choices. Instead, hiding refers to the moments where my participants would suppress pieces of their authentic selves, thoughts, or emotions. For some participants, this looked like trying to hide or quickly change their bodily reality. For other participants, they focused more on hiding their thoughts and feelings.

Challenging: Explain, Humanize, & Resist

All my participants, in one way or another, expressed feelings of exhaustion and frustration with the ways they received health care treatment. Many of them shared how they just wanted to be treated like real people, rather than just a fat body. Where conforming behaviors were primarily used by my participants to protect themselves, challenging behaviors used more to stand up for or advocate for oneself. My participants described three main techniques for challenging stigmatizing situations; these are explain, humanize, and resist.

A few of my participants engaged in explaining as a way of challenging health care professionals' stigmatizing treatment. Van Amsterdam and van Eck (2019) also found this strategy was employed by their research participants. However, their definition of explaining is slightly different from what I use in this research. These researchers found that their participants used explaining to communicate aspects of their health statuses that justify their weight or the various reasons as to why they are not to blame for their fatness. This strategy allowed their participants to avoid being viewed as lazy, apathetic fat women and instead, showcased a "positive workplace identity" (van Amsterdam and van Eck 2019: 52). My participants engaged in explaining in a bit of a different way. Rather than focusing on creating a positive patient identity, which would be more in line with the conforming behaviors, my participants used this strategy to give context to their size, reduce blame for their fatness, or keep the conversation focused on their condition, rather than their weight. Overall, my participants used this strategy to

subvert their stigma and therefore, get their health care providers to appropriately interact with and treat them.

Fat women often have their humanity stripped away and their knowledge is frequently delegitimized (Ware 1992) in health care visits. To challenge this treatment, one participant, Anne described trying to humanize herself to her doctors, nurses, anesthesiologists, and surgeons in order to subvert any stigmatizing ideas they held about her and fat people altogether. Sometimes Anne would use communication tactics to convince her health care providers that she was a real person with hopes, dreams, and fears. She would talk about herself, and in particular, her desire to live after the upcoming procedure. Other times, Anne used a demonstration of emotion, such as crying, to humanize herself. Either way, Anne was trying to show that she cares about her life and health, which subverts the assumption that fat people are apathetic to their health statuses.

Of the stigma management strategies mentioned by my participants, resistance to the stigmatization process was by far the most common strategy mentioned. Over 80% of my participants mentioned at least one way they resisted the dominant notions of fatness. Without a doubt, the commonness of this strategy is connected to my participant's knowledge of fat activism. More than that, there is a connection here to fat activism in online spaces. Because fat individuals can share experiences, coping strategies, and stigma management tactics online, there is a strong undercurrent of resisting anti-fat bias among some fat communities.

My participants described multiple ways they enacted resistance. One of the most common ways my participants engaged in resistance was through refuting. Mentioned earlier in this written work, some of my participants explained how they would have rebuttals in their back pocket to use against inadequate treatment suggestions. This rebuttal was: "Let's assume I lose

weight and I'm still dealing with it [condition/symptom/etc.]. What interventions would you recommend then?" Being able to counter fatphobic and stigmatizing questions and advice was empowering for my participants.

Withdraw: Delay & Avoid

In Alegria Drury and Louis's 2002 study, they found a profoundly common pattern among fat women in association with their health care was how frequently they would delay or avoid their appointments. Their research participants listed 19 reasons for not attending an appointment such as not wanting to get weighed or being told they have to lose weight. In order to avoid stigmatization, these women disengaged from health care altogether. Because this study focused on the attendance of health care visits, this section of this chapter is not as robust as the rest. However, it is worth mentioning that a few of my participants reported engaging in these same strategies, thus providing further evidence for Alegria Drury and Louis's (2002) research.

Though there are various ways for individuals to respond to stigmatizing situations, this section details the primary tactics that my participants described taking up when navigating stigmatization in health care settings. Some of these strategies encouraged my participants to conform to social standards in order to make it through their health care appointments. Other strategies encouraged my participants to resist their own discrimination. Ultimately, these stigma management, coping and advocacy strategies indicate that participants put in much time and effort in order to manage their stigmatized identity and receive adequate health care.

This study contributes to existing literature in a few ways. First, this study contributes to the expansive literature on *obesity* and fatness, outside of the context of how to eradicate it. Importantly, this study positions fat people as experts of their own lives and experiences. Fat people are left out of research due to our social assumptions about the deviance of our bodies and

our contributions to society (and therefore, research). This study affirms the life and health seeking, outside of weight loss, that fat people engage in. Second, this study adds to existing literature on stigma and stigma management strategies. There is very little research on fat stigma or how fat people manage said stigma. Furthermore, at the time of writing this, I am unaware of any research that connects stigma and health care. Thus, thirdly, this study contributes to both the sociological and fat studies literature by exploring how stigmatizing views of groups of people, namely fat people, can impact one's health care experiences.

Limitations and Recommendations for Future Research

Though this research is full of rich insight, this does not mean there were not limitations to this study. I will address these limitations and my responses to them. I will also address recommendations for future researchers who may continue the work I have started here.

A primary limitation of this work was the lack of diversity in my sample. Though I knew qualitative methods would not give my thesis any real sense of generalizability, I had hoped my study could give insight into the various health care experiences of fat people in the U.S. However, this was not the case. Though this study included the experiences of a Multiracial Black woman and an African American/Black woman, there is an overarching lack of perspectives from Women and other People of Color in this written work. As Strings (2019) encourages us to understand, anti-fatness is inextricably linked to anti-Blackness and racism. Thus, the overwhelmingly dominant White voices, including my own as the researcher, in this written work makes it less applicable or useful to Black, Indigenous, and other Communities of Color. This suggests that my sampling techniques were not efficient for recruiting a racially and ethnically diverse sample.

Furthermore, there is a lack of gender variety in my sample. All of my participants identified as women, leaving out fat cisgender men, transgender men, transgender women, nonbinary, and other genders voices. It was not an intentional choice to exclude any gender from this study. Rather, cisgender women and non-binary individuals were the only individuals to respond to my call for participation. Furthermore, cisgender women were my only participants who scheduled interviews with me. This suggests that my sampling techniques were not efficient for recruiting a gender diverse sample.

Additionally, the education-levels and insurance status of my participants contributed to a lack of diversity. All my participants held higher education degrees that ranged from associate degrees to PhDs. I cannot say with certainty that there is a direct or causal relationship between this and my participants insurance statuses, as I did not directly ask questions related to careers or health insurance. However, it seems that there is a connection there. None of my participants shared any stories of navigating health care systems without insurance. One participant mentioned having just received insurance from her job, but we did not explore what it is like to be a fat person seeking health care without insurance. This was more due to my own insurance privilege and therefore, not considering the research value of asking about navigating health care systems without insurance.

Overall, the dominant voices in this study are White, educated, young-to-middle aged, cisgender women. Though there were some folks outside of these identity categories, the overall identity make-up of my sample clearly limits this study's ability to accurately represent the experience of fat people, broadly, navigating U.S. health care. My study does little to acknowledge the experience off fat people within the context of systemic racism, cissexism, and classism.

A final limitation of this study is that I was the only researcher conducting data collection and analysis. Thus, this study was heavily dependent upon my own research skills and was likely influenced by my own under- or un-checked biases. Furthermore, my presence as a fat, White, nonbinary, queer, academic researcher could have affected both the recruitment of participants and the responses I received in my interviews.

Incorporating the myriad of voices in a study of fat stigma and health care experiences would have made this thesis a more robust contribution to the field of sociology and the interdisciplinary area of fat studies. Researchers seeking to expand upon this written work could do so by 1) expanding recruitment sites to more than just the few online locations I utilized, 2) work with other researchers who holds the identities missing from this thesis so that all parts of the data collection, analysis, and discussion of the data can be involved with someone who has intimate and personal knowledge of these identities.

This study could be the foundation to multiple future studies. One area that fascinated me was the intersection among fat women, mother/parenthood, and health care. My participants who had children mentioned how their connection to bodies, their own and their children's, transformed through their child-bearing and rearing processes. Furthermore, some of these moms hinted at the sense of responsibility for advocating for their children and teaching them ways of taking care of their bodies. Where these moms struggled to advocate for themselves, there were few feelings or experiences that prevented them from advocating for and protecting their children.

Another future study could center the role of the internet in fat activism and (fat) stigma management. Though Charlotte Cooper's 2016 book *Fat Activism* details the history of this social movement in the U.S., there is something interesting here about the sharing of knowledge,

advocacy tactics, and empathizing with negative and stigmatizing situations. Although I only briefly addressed this in this written work, much of my participants self-advocacy tactics and stigma management strategies are absolutely connected to what they have learned in online fat spaces. This does not mean all my participants' knowledge comes from these spaces. Future research could help illuminate how online fat positive spaces are impact fat lives and fat health care.

Because I did not get to fully explore this, I also feel compelled to mention that studying fat sexual health would be another interesting direction to go for future research. Something a few of my participants mentioned was the mixture of de-sexualizing and fetishizing of their fat bodies. In particular, when doctors assume that either fat people could never have sex because of their own lack of desire or because of other peoples' lack of desire, this can negatively impact fat people's sexual health. This may lead fat people to assume they do not require any reproductive or sexual health appointments. This could also lead to further barriers in accessing birth control, STI screenings, pap smears, and other reproductive or sexual health-based services and visits.

To conclude, my primary objective with this research was to understand and unveil U.S. fat patients' health care experiences, both *good* and *bad*. As both a sociological researcher and a fat person who has avoided most health care appointments since turning 18, this study means a lot to me. Through this research process I was exposed to many traumatic, discriminatory, and violent stories from fat women who have been denied medical treatment, ridiculed for their bodies, and made to feel unworthy of health care. At the same time, this research process unveiled to me the resiliency of fat people. We might live in a world that wants to shrink us, yet we continue to make and take space.

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Appendix A: Recruitment Flyer

Western Michigan University Department of Sociology Call for Participation

Master's student seeking participants for thesis research on Fat American's healthcare experiences.

My name is Danielle Snow, and I am a Master's student in the Sociology department at Western Michigan University. I am conducting a research project on Fat people's experiences with healthcare visits in the U.S. Participants will engage in an approximately 60 to 90-minute semi-structured interview that will focus on their experience with healthcare. This includes the impacts these visits have on their lives, negative or positive experiences with medical personnel, and the emotions that arise before, during, and after these visits. Interviews will be conducted virtually, either over the phone or through a video chat service. Before each interview, participants will be asked to fill out a letter of consent. Participants will be asked questions about their lived experiences as a Fat person seeking health services. This will include questions about. Participants will also be asked to fill out a short demographics survey. The maximum time commitment for this study is 90 minutes.

Study Qualifications- Participants must meet the following criteria to participate:

- Be 18 years or older
- Self-identify as Fat
- Live in the U.S.
- Attended a healthcare visit within the last three years
- Be comfortable discussing your lived experience as a Fat person in the U.S. and other personal information including, but not limited to: positive and negative healthcare visits and interactions, gender identity, racial identity, body image, stigma, discrimination, and stereotyping.

If you would like more information about participation, please contact Danielle Snow by email Danielle.p.snow@wmich.edu or phone (989) 550-0397.

Appendix B: Informed Consent Document (IRB Approved)

WESTERN MICHIGAN UNIVERSITY

IRB Approved

Approved for use for one year from this date:

FEB 08 2021



WMU IRB Office

**Western Michigan University
College of Arts and Sciences**

Principal Investigator: Ann Miles
Student Investigator: Danielle Snow
Title of Study: The Weight of The Interaction: An Exploration of Fat People's Experiences in Healthcare Settings

STUDY SUMMARY: This consent form is part of an informed consent process for a research study, and it will provide information that will help you decide whether you want to take part in this study. Participation in this study is completely voluntary. The purpose of the research is to unveil the lived experiences of fat people in the U.S. seeking healthcare services. This project will serve as Danielle Snow's thesis for the requirements of the Master's of Arts in Sociology from Western Michigan University. If you take part in the research, you will be asked to participate in an interview with Danielle to discuss your own experiences in medical or healthcare settings. Your time in the study will take 45-90 minutes to complete. The possible risk for taking part in the study may be distress from discussing body image, discrimination, or healthcare encounters. The potential benefits of taking part may be empowerment from having the chance to discuss your lived experiences in an affirming space. The alternative to taking part in this research study is not to take part in it. There is no cost to participate in this study.

You are invited to participate in this research project titled "The Weight of The Interaction: An Exploration of Fat People's Experiences in Healthcare Settings." The following information in this consent form will provide more detail about the research study. Please ask any questions if you need any clarification that may help you decide if you wish to participate in the research study. You are not giving up any of your legal rights by agreeing to take part in this research or by signing this consent form. After all of your questions have been answered and the consent document reviewed, you will be asked to confirm or deny your participation in the study. If you deny participation, there will not be an interview. If you confirm, your participation in the phone/online interview indicates your consent for use of the answers you supply.

This study aims to find out your experiences as a fat person seeking healthcare services.

You may participate in this study if you are 18-years-old, living in the U.S., and have attended a healthcare appointment within the last three years. You must have access to a computer or laptop with internet access or a telephone that has calling capabilities or internet access.

Interviews for this study will be over the phone or the video calling platform, Webex. We will use whatever communication method is most convenient for you. You are encouraged to find a quiet, safe, and comfortable location to sit during these interviews.

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date:

FEB 08 2021



WMU IRB Office

The interview will take 45-90 minutes. The student investigator may contact you via phone or email for a follow-up for 20 minutes or less.

If you choose to participate in this study, you will be asked about your experiences in health care settings. If you agree, the student investigator will request that to audiotape the interview. You can decline audiotaping and still participate in the study.

There are no measurements for this study.

There are minimal potential risks for participating in this study. It is possible that you could experience distress when speaking about body image, discrimination, or healthcare encounters. If you indicate any signs of distress from the interview questions or say you cannot continue the interview for any reason, the interview will be stopped. The student investigator will provide you with mental health hotline resources if you display any signs of distress throughout the interview. Your name will not appear on any document, and the student investigator will use a pseudonym (fake name) on all notes and in any published work. Identifying information such as last names, addresses, and employment will not be collected.

There are no direct benefits to you of participation. A potential benefit of this study is to gain empowerment by being given the opportunity to discuss your lived experiences. You may feel heard and validated after the interview. Sociology as a discipline will benefit from this study by having new literature to fill in gaps about the lived experiences of fat people in the U.S. There is very little scholarly work on fat folks seeking healthcare. Thus, this research will expand the literature and propose new areas of study for future research.

The only cost to you is the time needed to complete the interview.

There is no compensation to you for participating in this study.

Only the student investigator will have access to the information collected in this study. All participants will be given a pseudonym in any published work and in all note-taking by the student investigator. This study will be considered as a thesis. This thesis will eventually be published and available on Western Michigan University's Scholar Works archive. Results from the study may also be presented at professional academic conferences.

The information collected about you for this research will not be used by or distributed to investigators for other research.

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You can choose to stop participating in the study at any time for any reason. You will not suffer any prejudice or penalty by your decision to stop your participation. You will experience NO consequences either academically or personally if you choose to withdraw from this study. The investigator can also decide to stop your participation in the study without your consent.

Should you have any questions prior to or during the study, you can contact the principal investigator, Dr. Ann Miles, at (269) 387-5383 or ann.miles@wmich.edu or the student investigator, Danielle Snow, at 989-550-0397 or Danielle.p.snow@wmich.edu. You may also contact the Chair, Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298 if questions arise during the course of the study.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) as indicated by the stamped date and signature of the Board Chair in the upper right corner. Do not participate in this study if the stamped date is older than one year.

Participating in this phone/online interview indicates your consent for use of the answers you supply.

Appendix C: Demographics Survey & Interview Guide

Survey & Interview Guide

- I. Note to Self: LOCK THE MEETING ROOM
- II. Survey
 - a. Is there a preferred pseudonym (fake name) you would like to go by for this research? If so, what would that be?
 - b. What is your age?
 - c. What is your gender identity?
 - d. What is your race and ethnicity?
 - e. What is the highest level of education you have completed?
 - f. What words would you use to describe your body? (Ex. Plus size, Fat, Chubby, etc.)
 - g. Are you familiar with Fat Acceptance and/or Body Liberation?
 - h. Are there any other important identities to you that I did not ask you about?
- III. Interview Guide
 1. Introduction
 - a. Do you identify with the word “fat”?
 - i. Why/Why not?
 - ii. What does it mean to you?
 - b. How would you describe the treatment of fat people in the U.S.?
 - i. Why do you think fat people are treated this way?
 - c. What kind of relationship have you had/do you have now with your body?
 2. Health, Wellness, & Experience
 - a. What does it mean to be “healthy”?
 - i. How does someone know if they themselves are healthy?
 - ii. How do others know if someone is healthy?
 - b. What does it feel like to think about going to a health care appointment?
 - i. What does it feel like for you to make a health care appointment?
 - c. Do you do anything to prepare yourself for a healthcare visit?
 - i. If so, what? What does it look like?
 - d. Have you experienced positive healthcare visits?
 - i. What was that like? What made it positive?
 - e. Have you experienced negative healthcare visits?
 - i. What was that like? What made it negative?
 - f. Do you generally feel welcomed or unwelcomed in healthcare spaces?
 - i. Why or why not?
 - g. Would you say you generally advocate for yourself in healthcare visits?
 - i. Why or why not?
 - h. What do you do after healthcare visits?
 - i. Do you engage in any form of self-care after healthcare visits?
 3. Wrapping Up
 - a. Do you have any community to express your experiences with?

- i. If so, what do you talk about?
 - ii. What does it feel like to have this community?
- b. What do you wish healthcare visits would feel like?
- c. If you could tell the medical industry anything at all, what would it be?
- d. Is there anything else you'd like to add about your experience with healthcare visits?
- e. Is it okay to email you if I have follow up questions?

Appendix D: HSIRB Letter of Approval

WESTERN MICHIGAN UNIVERSITY



Human Subjects Institutional Review Board

Date: February 8, 2021

To: Ann Miles, Principal Investigator
Danielle Snow, Student Investigator

From: Amy Naugle, Ph.D., Chair

Re: IRB Project Number 21-01-10

This letter will serve as confirmation that your research project titled “The Weight of The Interaction: An Exploration of Fat People's Experiences in Healthcare Settings” has been **approved** under the **expedited** category of review by the Western Michigan University Institutional Review Board (IRB). The conditions and duration of this approval are specified in the policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note: This research may **only** be conducted exactly in the form it was approved. You must seek specific board approval for any changes to this project (e.g., **add an investigator, increase number of subjects beyond the number stated in your application, etc.**). Failure to obtain approval for changes will result in a protocol deviation.

In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the IRB for consultation.

The Board wishes you success in the pursuit of your research goals.

A status report is required on or prior to (no more than 30 days) February 7, 2022 and each year thereafter until closing of the study.

When this study closes, submit the required Final Report found at <https://wmich.edu/research/forms>.

Note: All research data must be kept in a secure location on the WMU campus for at least three (3) years after the study closes.