

“LET’S TALK ABOUT YOUR WEIGHT”: HOW FATPHOBIA MANIFESTS IN THERAPY

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ABSTRACT

Fat people experience individual and structural oppression in a variety of cultural and relational arenas. Experiences of fatphobia are shaped by body discourses, neoliberal agendas, and the medical model. This dissertation uses semi-structured narrative interviews and visual data to explore fat clients' body histories and how their experiences of fatphobia are reproduced within the therapeutic space. Therapy is another arena where fat bodies are disciplined, operating as a vehicle to transmit dominant expectations to citizens. Cultural, medical, and psychiatric understandings of "obesity" permeate therapeutic interactions, linking mental illness and physical embodiment. Therapists often entrench client/clinician power relations, reinscribe client deviance, and promote weight loss. When clients attempt to challenge or shift the narratives around their body, therapists become defensive. Mental health practitioners have an ethical obligation to treat clients with dignity and respect, regardless of body size. It is vital for therapists to engage in reflexive practices and to think critically about whether they are meeting client needs or acting as agents of social control. Fat Studies, fat activism, and anti-oppressive practice principles offer therapists lenses to contextualize fat clients' experiences within broader structural and systemic power relations, rather than seeing fat bodies as individual examples of deviance. This dissertation outlines practice recommendations for therapists so that body work can be undertaken from an emancipatory lens.

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DEDICATION

For the Village.

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CHAPTER ONE: INTRODUCTION

This dissertation considers the ways that fat bodies are marginalized within the therapeutic relationship. Even though therapists have an ethical obligation to challenge their own biases and treat all clients with dignity and respect, there is a significant gap in therapeutic education and practice around body size. This dissertation is grounded in fat feminist scholarship and uses a Fat Studies lens to explore how fatphobia permeates clients' histories and then manifests in the therapeutic relationship, even as fat clients seek a safe space to unpack histories filled with body and size-based trauma.

Fatness is a shifting category that intertwines with political, neoliberal, social, cultural, relational, political, medical, and psychiatric lenses. The therapeutic relationship lives in the intersection of communication and culture and reflects and interrogates both. Explorations of how fatphobia manifests in the therapeutic relationship cannot fully be captured by looking only at communication within therapy. What emerges in the therapeutic space is informed by fat clients' cultural experiences, body histories, barriers to access, and the ongoing messages that they receive as they move through the world. This dissertation is structured to explore the discourses, barriers, messages, assumptions, and experiences that inform what fat clients and their therapists are bringing to the therapeutic relationship, and the subsequent interactions that take place.

Chapter Two begins by exploring the dominant discourses that enact discipline on fat bodies such as neoliberal ideals, the eugenics movement, the medical model, and the Body Mass Index. Chapter Two also examines the therapeutic relationship as an exercise of power and control, a mechanism for communicating dominant ideals to citizens and bringing their

behaviour into line. This chapter concludes by examining fat activism and anti-oppressive practice as ways to resist and subvert fatphobic power relations in the therapeutic relationship.

Chapter Three describes the methodological considerations underpinning this research, reviewing the trend of dominant “obesity” studies that further the marginalization of fat people, rather than seeking to challenge fat stigma. This chapter also outlines the recruitment and interview processes and summarizes participant demographic data.

Chapter Four explores the messages that participants receive about their bodies in public spaces, at work, when buying clothes, within their families, and when dating or in romantic relationships. Participants experience abjection in all these spheres. Participants’ experiences of abjection, rejection, hostility, and micro-aggressions resulted in increased policing of the self and the body, and disembodiment as a form of coping.

Chapter Five explores how participants connected with the fat community to cope with consistent experiences of abjection. The fat community made space for participants to resist dominant body discourses and offered them opportunities for connection, acceptance, art, performance, and activism. Claiming fat as a political identity and fostering connections with like-minded people allowed participants to create alternative stories about themselves and their bodies. This chapter also discusses some of the limitations of the fat community.

Chapter Six focuses on participants’ experiences within the medical system. Participants discussed encountering significant discrimination within the medical and psychiatric systems. Medical practitioners overwhelmingly focused on weight loss and withheld care from participants as an incentive. These interactions resulted in participant anxiety and avoidance. Participants described internalizing negative medical encounters and turning to disordered eating

and other harmful body practices. The exploration of how fatness is disciplined by medical and psychiatric discourses sets the stage for participants' experiences in therapy, as therapeutic practices and treatment plans are influenced by the medical model and often take place within medical settings.

Chapter Seven provides an in-depth impression of participants' experiences in therapy. Participants discussed that their therapists often made their weight the problem even if they were not in therapy to discuss their bodies. Therapists also had inappropriate boundaries, perpetuated microaggressions, discussed their own bodies, and issues of countertransference were common. Participants described how they resisted within the therapeutic space, often using education as a tool. Barriers such as physical space, cost, and wait time were also discussed. Participants also explored what their therapists did well when it came to discussing body and fatness and discussed how other therapists could replicate a positive and gentle approach.

Chapter Eight concludes the dissertation, emphasizing the importance of incorporating fat liberation and anti-oppressive approaches into therapy. This chapter makes recommendations for practice and discusses future directions for research.

Why This Research?

I discovered the fat acceptance movement online in 2009 and began to think about my body (and fat bodies in general) in a newly politicized way. As I gained anecdotal and academic knowledge about fat bodies, I began to make connections to my professional life. I have worked in the social work field in a variety of different settings since 2010. I have seen the ways that stereotypes and negative assumptions about fat bodies permeate socialization between staff, clinical interactions with clients, physical space, available services, and recommendations and treatment plans. As I

discuss in more detail in Chapter Three, most research about “obesity” or fatness researches about fat people, rather than with them. Assumptions about fat people are made, while fat peoples’ voices are absent or ignored. Therapeutic research and practice privilege the observations and actions of the clinician over the experiences of the client. Practitioners often fail to account for client expertise and broader experiences within the therapeutic relationship. This research intentionally privileges participants’ lived experiences, understandings, and expertise. My research questions were generally, “How does fatphobia impact participants’ lives?” and more specifically, “How do bodies and body size come up in the context of a therapeutic relationship?”. Clients bring all of themselves to the therapeutic relationship. This research sought to include broader body histories and lived experiences of fatphobia, rather than distilling experiences down to only what takes place within the therapeutic space.

Researcher Positionality

Locating myself in this dissertation and discussing my interest in this topic makes me visible as an author. It is important to me to challenge oppressive structures within academia that assume that knowledge is neutral and that an all-knowing expert position is possible (Absolon & Willet, 2005; Potts & Brown, 2005). I have lived, personal, academic, and professional experience with complex, overt, and covert manifestations of fatphobia, but I am certainly not neutral. I have some very particular understandings that I bring to this research, which are shaped by my life experience as someone who politically identifies as fat. My experiences have and continue to be shaped by what it is like for me to move through the world as a fat person. My fat body has caused me to be harassed, bullied, discounted, and excluded in ways that tangibly demonstrate the disgust that society at large holds for my body type and others like it.

Reclaiming the word fat has been a powerful way for me to create the political space to challenge the unquestioned negative associations with fatness. Though I choose to define myself as fat, fatness is not a category that is static. Fatness can be slippery, fluid, changing, and difficult to pin down. My body size interacts with my gender, age, ability, sexuality, race, class and all other aspects of social location. Definitions of fatness can differ based on other aspects of identity. Many of the barriers and experiences of discrimination that my participants discuss throughout this dissertation are my experiences as well. I have been overtly harassed and covertly judged while trying to navigate public spaces. I struggle with how much space my body takes up while on public transit, and the reactions of other riders. I do not fit well into certain restaurants, seats, and tight spaces. I have had past work experiences where I watched people with far less experience but smaller bodies getting hired or promoted over me, especially when I worked in the retail and restaurant industries, where importance is placed on a worker's appearance and how well they are able to "represent the brand" or "create a dining experience". Even though more plus-size clothing options are available now (though current options still favour fat people on lower end of the size spectrum), I remember struggling to find clothes that fit as a child and a teenager. Within my family, my body size was a topic of discussion as I was growing up, eliciting praise when I got smaller, and concern when I got bigger. I have been consistently mistreated, belittled, ignored, or denied appropriate care in medical encounters. I am privileged to have a family doctor who is supportive, but because I have a physical disability I also come into contact with a variety of other specialists who believe that pressuring me to lose weight or get weight loss surgery will fix the structural malformations in my legs that I was born with. These structural issues constrain my mobility regardless of my weight. Like most fat people, I have been unable to consistently produce a thinner, more socially acceptable body. I

have never been thin, but I remember the differences in my life when I was smaller, the attitudinal and physical barriers that disappeared, the way people treated me better.

Fatness also exists on a spectrum, and though I am suspicious of the implications that come with trying to quantify fat bodies, for the sake of transparency I would consider myself to be what people in fat acceptance/activism circles refer to as a “mid fat”. Mid fat was also reflective in my experience of interviewing participants who were both smaller and larger than me, all of whom identified as fat. Having a mid fat body means it is important for me not only to name my fat experience, but to be able to see the ways in which being a mid fat afford me privilege. For example, I can find brick and mortar plus-size stores that carry clothing in my size, the last time I was on an airplane I was just able to buckle the seatbelt without an extender, I have ultimately been able to build a career and get hired in clinical health care settings where I earn a similar income to that of my thinner colleagues. I experience barriers, but not to the extent that larger fat people do. It is important for me to be an ally to larger fat people, many of whom trusted me with their stories for this dissertation.

Professional Observations

Most of my research participants experienced judgement from their medical and mental health practitioners. Throughout my career I have observed fatphobia manifesting in the social service agencies and health care organizations that I have been employed at. The following is an excerpt from a paper I wrote in 2012, while completing my Bachelor of Social Work:

I have noticed rampant sizeism and weight discrimination being openly discussed by staff and service users. The staff team (comprised of mostly women) are constantly engaging in diet talk and negative body commentary. Every time a staff member has a birthday, we get them a birthday cake, and awkwardness ensues. Half the staff refuses to eat the cake

for dieting reasons, or because cake is “bad”, and the other half will take the cake but feel guilty and apologetic about their “failure”.

This was my first academic attempt to put into words the ways that I saw fatphobia creeping into my workplace amongst the staff. Sadly, food moralizing and dieting have continued to be a feature of every social work workplace I have ever been a part of. Staff who are careful around issues of race, gender, ability, and sexuality, who understand the importance of language, will nevertheless engage in a punishing discourse around food consumption. “No matter where therapists find themselves on the continuum of size acceptance, it’s our duty to become more aware of this issue and familiar with the research. By increasing awareness of our own behaviours in our professional and personal lives - negative comments about weight, fat jokes, talking about being “good” or “bad” in reference to eating behaviours - we can help change societal norms” (Matz, 2011, p. 26). These food-centric experiences led me to be more observant of other ways that fatphobia and sizeism were influencing the social service practitioners I worked with.

Many social service environments operate in small spaces. A colleague once had to advocate for more than a year to get a chair that the majority of their clients would be able to fit into. They experienced significant pushback from management, even though the width and structure of the chairs in their office were not meeting client needs. I learned at this time that the term for a chair that can support a variety of bodies is a “bariatric chair”. Bariatrics is the branch of medicine that deals with the study and treatment of “obesity”. This is an example of how medical models of fatness come to bear on all aspects of a fat person’s life, including on the organization of physical space. I declared in a team meeting that I found the repeated use of the term “bariatric chair” unacceptable, and then had to explain why I found it offensive. My

participants raise the impact that therapeutic office and waiting room spaces had on them in Chapter Seven.

Dominant ideas about fatness also come to bear on what programs and resources are made available to clients. In a community health care setting that I worked in, anti-obesity initiatives meant that most of the programming budget was funnelled into fitness programs and programs aimed at diabetic interventions. I raised with a colleague that I thought it would be valuable to run a program focused on body image and body acceptance. Her response was that our workplace could not be seen to be “promoting obesity”.

Some of my research participants made connections between the ways that their medical practitioners and their therapeutic practitioners approached their body size, physical and mental health, and diet and lifestyle. Having worked on part of interdisciplinary health teams including doctors, nurses, dietitians, social workers, and health promotion workers, I have seen weight loss be emphasized over all other priorities, even if clients are severely marginalized in other areas of their lives. Dominant medical understandings of bodies and health are privileged in spaces where clinical professionals with different disciplinary backgrounds come together.

Since fatphobia permeates socialization between staff, the physical space and furniture in an organization, and the programs and resources that are available, I wanted to know more about how fatphobia influenced one-on-one interactions between fat clients and practitioners. I have observed in a variety of work settings that staff members often seem less willing to work with or help fat clients. At one of my first social work jobs I overheard a social service worker complaining that she had a new client who wouldn't fit in her cubicle, and that she would have to do extra work to find somewhere else to meet with the client, since she couldn't see a way to avoid providing service to her. The subtext of this whole discussion was that she wouldn't have

to do all this extra work if the client was the size of a “normal person” (though our cubicles and chairs were small enough to make navigation challenging for most people, regardless of size).

The client that she was speaking about met with her once and never returned. I often wonder if it was because she was aware that the worker was feeling hostile towards her body and resentful of having to change spaces. That encounter happened in an office where everyone had cubicles and could be overheard. If that kind of interaction was openly happening in a setting where staff often self-regulated their behaviours and responses because they knew management and colleagues could overhear and observe them, I wondered what was happening in therapeutic settings, in private offices, behind closed doors.

Pushing Back in the Workplace

I already feel hypervisible as a fat body working in a health care context, so challenging ingrained ideas about fatness in a professional setting is often difficult for me. My biggest activist strategies involve discussing the power of language, refusing to participate in body shaming or diet talk, drawing attention to spaces I can't comfortably fit into, having medical statistics and academic resources on hand to challenge the idea that people can lose and keep off significant amounts of weight, highlighting the dangers of weight cycling, and exposing fatphobia as a legitimate form of marginalization. Even though I confidently speak about my experiences with disability when necessary, to educate about ableism in workplaces, and I discuss being mixed-race to draw attention to racial dynamics and tensions that permeate work relations, when it comes to fatness, I am often silent. While I have strategies for approaching fat discussions, I know who my allies are, and I know who won't be receptive. Fighting dominant ideas about weight and health in a health care setting as a fat person is often a battle I avoid, knowing that my own body will be used to discount my arguments.

I hope this dissertation will help contribute to a growing body of knowledge about weight stigma and that it will be used as an educational tool to help to shift workplace cultures that enforce weight loss in social, medical, and therapeutic settings.

CHAPTER TWO: THEORETICAL FRAMEWORK

Fat bodies are understood to be abnormal. This abnormality is reinforced by dominant body discourses, neoliberal ideals, the eugenics movement, the medical model, and the therapeutic relationship (Davies, 2005; Guthman, 2009; Stubblefield, 2007; LeBesco, 2009; Solovay, 2000; Mik-Meyer, 2010; Cooper 1997; Foote & Frank 1999). Fat people are marginalized individually and systemically in a society that seeks to eliminate fat bodies. Fat activism is a social movement that uses a wide variety of strategies to push back against fatphobia. Fat Studies is an academic field that seeks to challenge assumptions and biases around fat bodies. Fat activism and Fat Studies provide a lens to explore participants' body histories and their experiences in therapy. Anti-oppressive practice is an approach to therapeutic encounters that connects the personal and political and can guide therapists to challenge their own biases around fatness. Anti-oppressive practice encourages therapists to participate in individual and systemic activism against dominant healthist, ableist, and fatphobic discourses that surround bodies.

The Discursive Framing of Bodies

Body size is often an area of silence. Things don't need to be said because they are assumed and already functioning within a preconceived set of rules.

Silence itself – the things one declines to say, or is forbidden to name, the discretion that is required between different speakers – is less the absolute limit of a discourse...than an element that functions alongside things said, with them and in relation to them within all over strategies... We must try to determine the different ways of not saying such things, how those who can and those who cannot speak of them are distributed, which type of discourse is authorized..." (Foucault, 1980, p. 27-28)

Bodies have been constrained to lead a discursive existence (Foucault, 1980). Fat discourses are shaped by the “manifold mechanisms which, in the areas of economy, pedagogy, medicine, and justice, incite, extract, distribute, and institutionalize” (Foucault, 1980, p. 33). Where there is desire and drive to be thin, to change the body so one achieves a body that is “normal”, a power relation is already present (Foucault, 1980). Dominant body discourses are experienced differently by everyone depending on their intersectional realities. Experiences of fatness intertwine with body size and shape, race, ability, gender, and sexuality, “as well as with impactful socioeconomic and historical forces underpinning these, including colonialism, neoliberalism, geopolitics, and beyond” (Rinaldi, Rice, & Friedman, 2019, p. 2). Our understandings of body discourses and the surrounding individual, social, and cultural circumstances creep into professional and personal relationships.

Foucault’s (1980) discussion of the principle features of power demonstrates how fat oppression is organized discursively in society. Power functions by establishing a negative relation; no positive connection is established between power and fat, resulting in rejection, exclusion, refusal, concealment, or masking (Foucault, 1980). Where fat and bodies are concerned, “power can ‘do’ nothing but say no to them; what it produces...is absences and gaps; it overlooks elements, introduces discontinuities, separates what is joined,” like body and mind, “and marks off boundaries” (Foucault, 1980, p. 83). What are the boundaries between normal and abnormal bodies? The spectrum of fatness is to be deciphered on the basis of its relation to the order. Power engages fatness in a cycle of prohibition. The objective is that fat renounce itself. Renounce yourself, declare yourself unhealthy, lose weight, or suffer the penalty of being suppressed (Foucault, 1980). “Do not appear if you do not want to disappear. Your existence will be maintained only at the cost of your nullification” (Foucault, 1980, p. 84). Many fat activists

have discussed how the fat body is only allowed to exist on the way to being thin (Cooper, 1997; Friedman, 2012; Kent, 2001; Mik-Meyer, 2010).

To put it bluntly, there is no such thing as a fat PERSON. The person is presumptively thin, and cruelly jailed in a fat body. The before-and-after scenario both consigns the fat body to an eternal past and makes it bear the full horror of embodiment, situating it as that which must be cast aside for the self to truly come into being (Kent, 2001, p. 135).

Placing bodies under the microscope of science, in the name of liberal projects of self-improvement, ultimately reinscribes their deviance and increases their oppression (Foucault, 1979). The discursive construction of the “obese body” has led to fatness not only being perceived as medically unhealthy, but morally unhealthy as well.

Fat people are continuously constructed as morally inferior (Mik-Meyer, 2010). Foucault (1985) describes morality as, “a set of values and rules of action that are recommended to individuals through the intermediary of various prescriptive agencies...” (p. 25). I am interested in how therapy functions as a prescriptive agency and how therapists transmit the rules of action to their clients. Morality also refers to the behaviour of individuals in relation to the rules and values that are recommended to them. Individuals are then judged on how much they comply with these rules and the manner in which they obey or resist an interdiction or prescription (Foucault, 1985). To better understand this paradigm in a contemporary context, it is important to delve into the relationship between fatness and neoliberalism.

Normative Neoliberal Bodies

Fat bodies are commonly viewed as a significant departure from a “normal” physical body, as supported by contemporary neoliberal discourses. Neoliberal capitalism not only demonstrates

its ideals in the sphere of the market, but in bodies as well (Guthman, 2009). The neoliberal subject is defined by consumption, individual responsibility, and self-control (Davies, 2005; Guthman, 2009). Fat people are often downwardly mobile, so they frequently fall short of the income necessary to have the capacity to purchase goods and be valued societally (Davies, 2005; Ernsberger, 2009). The definition of a successful life is based on limited notions of independence, competitive accomplishment, and mastery of certain skills, rather than on collaboration, community wellness, and collective strength (Stubblefield, 2007). People who are unsuccessful in these narrowly defined ways are disabled by being treated as less than human and deprived of opportunities to participate as citizens (Stubblefield, 2007). A crucial element of the neoliberal order is a shift from dependence on social support to the dream of possessions and wealth for each individual who “gets it right” (Davies, 2005). Fat people are individually blamed and pathologized for failing to “get it right” in the neoliberal system, rather than the focus being on removing the social and cultural barriers that prevent them from having the same opportunities as the dominant group (Herndon, 2002; Stubblefield, 2007). Neoliberal governmentality requires subjects to participate in society both as enthusiastic consumers and as self-controlled individuals (Guthman, 2009). Those who can achieve thinness amid plenty are seen as representative of rationality and self-discipline that those who are fat must logically lack (Guthman, 2009). Neoliberal, capitalist, and fundamentalist Christian discourses of productivity and self-deprivation as markers of success and privilege are evident in this line of reasoning, and these discourses influence health and therapeutic practices as well.

Characteristics assigned to members of subordinate groups include irresponsibility, laziness, intellectual deficiencies, asexuality, and sexual degeneracy (Mullaly, 2002). Current neoliberal constructions of normative bodies and successful subjects have been heavily

influenced by historical attempts to prevent the degeneration of the White race (Stubblefield, 2007). While most people typically think of the eugenics movement as something in the past, it continues to influence scientific research and public policy today (Stubblefield, 2007). The eugenics movement is an important link between historical and contemporary understandings of bodily deviance. Eugenics influences how fat people are framed as inferior to the universal subject. Eugenics reflects a history with a dynamic set of discourses and practices that reflect what the socially powerful believe about the nature and meaning of intellect and civilization. Within the eugenics movement, people in positions of social power constructed and reconstructed certain groups as deviant to serve their own interests, and we are still seeing examples of this in contemporary neoliberal societies (Stubblefield, 2007). Eugenic viewpoints were convenient for policy makers who found it easier to pathologize certain groups rather than take responsibility for shifting their social conditions (Stubblefield, 2007).

The hardships experienced by marginalized groups are often created by state-sponsored examples of ableism or fatphobia (Sherry, 2004). An example of this were The Ugly Laws which existed from the 1860s to the 1970s in many American cities and effectively banned people with physical abnormalities from appearing in public (Schweik, 2009). The Ugly Laws were inspired by the eugenics movement and involved both a judgement of “abnormal” bodies and the use of the law to repress the visibility of human diversity (Schweik, 2009). They were supported by a state positioning of disability as an individual problem rather than a problem of social inequality, and we continue to see this happening for both fat people and people with disabilities, supported by new forms of biotechnology. The new eugenics movement is aimed at abolishing aberrations deemed socially or aesthetically undesirable, whether they are life threatening or not (LeBesco, 2009). This practice strips life of its humanity by focusing on a single trait that obliterates the

whole (Parens & Asch, 2003). One key component to contemporary eugenics rests in the primacy of the medical model and the use of the Body Mass Index (BMI) as a tool of control.

The Medical Model

The medical model is the dominant theoretical framework that currently deals with “obesity” (Cooper, 1997). “Medical discourses permeate our understandings of our bodies’ functions and of how we live. These discourses quantify health, and link directly to the socio-cultural values given to different bodies” (Meerai, 2019, p. 90). An abundance of medical evidence and “common sense” knowledge supports the current way fat bodies are framed in Western societies. “Fat is a crisis brought about by a mismanagement of energy balance, it offers nothing of value, it is only an opportunity for intervention. It is always about health, and health is presented as an apolitical fact” (Cooper, 2016, p. 24). Being fat is accepted as undesirable because it is seen as innately unhealthy and is theoretically the primary cause of a multitude of preventable diseases (Cooper, 1997). “Medical discourses...play on the power dynamics of physical, material, and aesthetic associations with fat, declaring causes for fatness and how fatness can lead to supposedly detrimental physical outcomes: disease, disorder, condition” (Meerai, 2019, p. 91).

The assumption that fatness exclusively leads to a variety of ills creates a duty for medical practitioners and fat people to do something about it. When we view health as a duty, it begins to be enforced through forcing subordination to authority (Greco, 2004). “Speaking in the name of your health is one of the most powerful rhetorical devices” (Greco, 2004, p. 1). Our bodies are governed by fundamental ideas that people ought to want to be healthy, and that people ought to have the motivation to be healthy (Greco, 2004). Even in the face of the unparalleled failure of the medical model to find a “cure” for fatness, obesity experts continue to

turn to this framework for intervention options (Solovay, 2000). Cultural narratives of fatness are fueled more by the drive towards normative bodies than by solid medical evidence (Herndon, 2002).

Fat people have been consistently maltreated by a medical establishment seeking to eliminate the obese (Solovay, 2000). “Bad” fat people are not trying constantly to lose weight and are therefore undeserving of medical professionals’ help and understanding (Murray, 2008). “Good” fat people engage in all sorts of methods to try and make their body acceptably thin, often veering into weight-loss behaviours that would be considered unhealthy and harmful if their body was smaller, but because they are fat these behaviours are encouraged by doctors (Murray, 2008). Yet in a sense, fatness defies medical model analysis because the diagnosis is subjective and unstable (Herndon, 2002; Stubblefield, 2007). Part of the power of fat is that no standard definition exists (Herndon, 2002). Fat can mark any person and can be used as a basis of stigmatization in a wide variety of situations, particularly in the medical context (Herndon, 2002). This label has been and continues to be applied to people with a wide range of characteristics (Stubblefield, 2007).

LeBesco (2009) states, “Escalating levels of hype about the ‘obesity epidemic’ are apparent in medicalized rhetoric about body size as first and foremost a health issue (conveniently obscuring the moral and aesthetic objections that fuel the demonization of fat bodies)” (p. 71). Poole (2007) urges us to question who is able/allowed to produce the “obese” body. Where are these producers situated and what is their relationship to obesity? What is there to be gained through a dominant framing of obese bodies? How are the definitions of obesity to be used? What other explanations are negated by it? What do these definitions do? To what end? LeBesco (2009) and Poole (2007) demonstrate that it is important to be critical about who is

conducting obesity research, why they are looking at these topics, and what interests they are serving. Much of the existing research about obesity issues comes from the American Obesity Association (AOA) (Harding & Kirby, 2009). Their sponsors include: The American Society for Metabolic and Bariatric Surgery, International Federation for the Surgery of Obesity, Jenny Craig, Inc., Knoll Pharmaceutical Company, Weight Watchers International, Inc., Slimfast, and Medeva Pharmaceuticals, etc. (Harding & Kirby, 2009). Yet it is not recognized as a conflict of interest that the funding for the AOA (which frames obesity as a “health crisis”, an “epidemic”, and openly declares a “war” on these bodies) comes from commercial weight loss programs, pharmaceutical companies who sell weight-loss drugs, and doctors who profit from performing surgery on fat people (Harding & Kirby, 2009). This obesity research is predicated on the validity Body Mass Index and further entrenches this tool as the correct way to classify bodies.

The Body Mass Index

The Body Mass Index (BMI) has had a huge impact on the ways we categorize and view obesity. The BMI is a weight-for-height tool that is privileged by the medical model and upheld as the standard for classifying bodies (“Health Topics: Obesity”, 2013). The World Health Organization defines a person with a BMI greater than or equal to 25 as “overweight”, and a person with a BMI greater than or equal to 30 as “obese” (“Health Topics: Obesity”, 2013). Fat Studies scholars challenge the reliance on BMI as a measure of health, as it misses all of the social determinants of health. For example, Type 2 diabetes, the disease most linked with obesity through BMI-supported discourses, is increasingly being associated with poverty and marginalization, rather than body weight (Bacon & Aphramor, 2011). Understanding human bodies only in terms of weight and height is a complete oversimplification that makes intersectional experiences invisible.

Almost every study on obesity begins their introduction with a discussion about how obesity is astronomically on the rise. One of the reasons for the enormous jump in measurably larger bodies was the restructuring of the BMI scale in 1998. As a result of the BMI cut-off points that define “overweight” and “obese” being lowered, millions of people became fat overnight (Wann, 2009). In fact, BMI profiling “overlooks 16.3 million “normal weight” individuals who are not healthy and identifies 55.4 million overweight and obese people who are not ill as being in need of treatment” (Bacon & Aphramor, 2011, p. 14). Burgard (2009) goes further to say that 91% of what accounts for health outcome has nothing to do with BMI. Yet the Body Mass Index is the premise upon which we classify bodies, and upon which vast amounts of medical obesity research are funded. This demonstrates that the empirical basis for fat issues is often discursively constructed (Friedman, 2012). As the BMI maintains dominance, it is important to find alternative ways of understanding fatness and fat people. One such paradigm is found in the emergent work of the field of Fat Studies.

Fat Studies and Fat Activism

This dissertation relies extensively on examples of fat activism and the theoretical approaches in the field of Fat Studies. Charlotte Cooper (2016), a foundational fat activist and Fat Studies scholar, describes fat activism as being about political activism, community-building, cultural work, micro fat activism, and ambiguous activism. Fat activism “is also the relationships between the people doing activism, it is the cultural work they produce, it can be very small moments that happen within or beyond community...” (Cooper, 2016, p. 53) Grassroots groups have “built resources for self-esteem, fitness, fashion, socializing, medical advocacy, and defence from discrimination, while creating theatre, dance, music, poetry, fiction, magazines, film, and art” (Wann, 2009, p. x). One example of a grassroots group was the Chubsters, a fat

queer girl gang organized in 2003 by Cooper. “What began as a pretend gang spawned new ideas about what fat activism could be: weird, made-up, funny, joyful, multi-layered, multi-directional and open” (Cooper, n.d.).

Cooper’s (2016) discussion of micro fat activism is particularly relevant to this dissertation. “Micro fat activism does not rely on collective action, it can involve very small acts undertaken in isolation” (Cooper, 2016, p. 78). Cooper (2016) describes micro fat activism as activism that happens in the moment, such as researching something online, buying things, choosing to eat something, exercising, learning, playing with one’s identity, and speaking out against or talking back to fatphobic comments. This dissertation is full of examples of micro fat activism, where participants bought or made things that brought them joy, provided resources, and challenged comments from their doctors, psychiatrists, and therapists. “This is the work of gently – or not so gently! – drawing people’s attention to micro-oppression, but it also involves being visible to others in an unthreatening way and bringing fat consciousness to other conversations, for example in friendships” (Cooper, 2016, p. 79). Cooper (2016) argues that micro fat activism is a form of opinion changing. This opinion changing is individual work, but is also embedded in the community, as expressed when my participants tried to educate or change people’s minds in the hopes that a similar interaction would not happen to another fat person. Micro fat activism’s “quiet relational qualities and use of assertiveness strategies produces embodied esteem within its practitioners and supports them in creating liveable lives for themselves and others. In this way subtle personal and social transformations take place...” (Cooper, 2016, p. 82).

Fat Studies scholars work towards the inclusion of fat oppression in academic research and publications. “As a new, interdisciplinary field of intellectual inquiry, fat studies is defined

in part by what it is not” (Wann, 2009, p. ix). Fat Studies is not another arena where dominant ideas about fat bodies are accepted. Fat Studies scholars challenge the idea that fat people are ugly, that they can and should lose weight, that fat is a disease and fat people are unhealthy and short-lived (Wann, 2009). “The field of fat studies requires skepticism about weight related beliefs that are popular, powerful, and prejudicial” (Wann, 2009, p. x). Fat studies is a radical, revolutionary, social justice-oriented field. Fat studies grew out of various fat activist movements and activities. One commonly acknowledged important moment is when the National Association to Advance Fat Acceptance (NAAFA) was established in the US in 1969 (Wann, 2009). The creation of *The Fat Studies Reader* in 2009 was also considered momentous for the field. Wann (2009) argues that,

If you participate in the field of fat studies, you must also be willing to examine not just the broader social forces related to weight but also your own involvement with these structures...Every person who lives in a fat-hating culture inevitably absorbs anti-fat beliefs, assumptions, and stereotypes, and also inevitably comes to occupy a position in relation to power arrangements that are based on weight. None of us can ever hope to be completely free of such training or completely disentangled from the power grid (p. xi).

For many people, fat is not a simple descriptor. It is associated with many negative attributes such as being disgusting, lazy, ignorant, smelly, unattractive, undisciplined, gluttonous, unhealthy, sedentary, and much more (Harding & Kirby, 2009).

Fat scholars grapple with themes of medicalization, mediatization, aesthetics, desire, and morality, as they explore how fat bodies are constructed in Western society. Cooper’s academic and activist work has also drawn attention to the limitations of Fat Studies being a field that universalizes the American cultural experience. “Fat people are found in every culture; fatness is

part of the fabric of humanity and is not the domain of one country to export to others” (Cooper, 2009, p. 328). Fat Studies is continually working to expand, complicate, and “thicken” understandings and intersections of fatness, as well as to collaborate with other interdisciplinary disciplines such as Gender Studies, Disability Studies, and Queer Studies (Friedman, Rice, & Rinaldi, 2019).

One publication that has been particularly fruitful in grounding my theoretical perspective is Hartley’s (2001) exploration of how to make room for the fat body in feminist scholarship. Bordo (1993), Bartky (1990), and Wolf (1990) are feminist scholars who have analyzed how the processes of surveillance and self-surveillance serve to indoctrinate women into the idea that the ideal female body is small, passive, and does not take up additional space. They focus on the ‘tyranny of slenderness’ and how this impacts all women. Hartley (2001) states that in spite of “the prevalence of women who resist (or fail to resist) the tyranny of slenderness, the fat body has largely been ignored in feminist studies that attempt to theorize the female body” (Hartley, 2001, p. 61). Hartley (2001) theorizes that sexism is inherent in sizeism, and that rejecting fat oppression and embracing fat liberation can lead to “heightened feminist awareness” (p. 61). Hartley’s piece on how fat women have been left out of feminist literature is echoed in how fat people have been left out of anti-oppressive and radical social work literature. Much feminist and social work theorizing focus on anorexia and eating disorders, but not on the marginalization that ensues when one remains fat. This dissertation is attempting to bridge that gap and use feminist theorizing to name and focus on weight discrimination and how it manifests for fat people socially, in public space, during medical encounters, and within the therapeutic space.

The Therapeutic Relationship

Who is a therapist? It is important to clarify who is practicing therapy, as the therapeutic field spans multiple professions and designations. In Ontario, the Canadian province where this dissertation was completed, psychiatrists, psychologists, social workers, and psychotherapists are all therapeutic practitioners. These professionals can work in the public mental health sector, as well as have a private therapy practice. Psychiatrists are medical doctors (MDs) who specialize in mental health and can diagnose and prescribe medications. Therapy from a psychiatrist is covered by the Ontario Health Insurance Plan (OHIP), so if people are able to access a psychiatrist with a therapeutic practice, it is free. Many psychiatrists do not offer therapy, choosing to focus instead diagnosing, prescribing, and monitoring medications for a variety of mental health conditions and mood disorders. In Ontario, psychiatrists are regulated by the College of Physicians and Surgeons of Ontario. Psychologists have a PhD in psychology, they are not covered by OHIP, and they are regulated by the College of Psychologists of Ontario. Social workers who are practicing therapy are usually required to have a Master of Social Work (MSW) and be registered with the Ontario College of Social Workers and Social Service Workers. Private health insurance plans often cover a certain amount of therapy with psychologists and MSWs, but not psychotherapists. Psychotherapists are more often working in private practices instead of public mental health organizations and are not usually covered under extended health benefits, perhaps because they were an unregulated profession in Ontario until 2017. Psychotherapists are now required to be part of the College of Registered Psychotherapists of Ontario. Psychotherapy education is often done through private programs and institutions, and the length of their education varies. They are required to put in a certain number of clinical practice hours under supervision before they graduate and begin to work in the field.

Psychiatrists, psychologists, social workers, and psychotherapists often do overlapping or similar work. I have drawn on literature from all of these fields, and when discussing the literature I will reflect the terms used by the authors. I draw most on social work literature, as social work literature challenges the power relations inherent in the therapeutic relationship and questions the aims and functions of therapy. The therapeutic relationship often functions as a form of control for citizens who are considered deviant and works to bring their behaviours into line with dominant expectations. This function of power needs to be understood as marginalizing bodies that are perceived as deviant because of their size (Friedman, 2012). The existing literature focusing on fatness and the therapeutic relationship is currently extremely limited. The literature that does exist focuses on obesity as a public health and public policy issue and uses words like “alarming”, “epidemic”, and “public health crisis” (Eliadis, 2006; Lawrence, Hazlett, & Hightower, 2010; Melius, 2013; Sealy, 2010). Friedman (2012) is the singular example of social work literature that takes a critical and social justice orientation to fatness and fat issues, challenging dominant narratives of fat bodies. It is important to fill this research gap by conducting research that brings forth the voices of fat people and their understandings of their experiences.

This dissertation critically analyzes the therapeutic professions, what principles guide them, what they are trying to do, and who they are serving. I look to anti-oppressive social work literature, which broadens the focus from individual symptoms to structural barriers and systemic oppressions. Fat Studies literature and anti-oppressive social work literature come together to offer an understanding of fatphobia from a structural lens. It is valuable for all therapeutic practitioners to build an understanding of fatphobia that acknowledges the structural, societal,

and cultural barriers that fat people face, rather than viewing fat clients as people to be managed through individual interventions.

Power Relations in Therapy

The therapeutic relationship is often a mechanism to reinscribe deviance and to promote self-improvement. Foote & Frank (1999) discuss therapy as an institution that is “apparently benign and outside relations of power yet a strategy by which power shapes the self in ways that do violence to the self” (p. 154). They draw on Foucault’s exploration of technologies of the self, defining therapy as a “truth game” where individuals by their own means or with the help of others enact operations on “their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality” (p. 161). Truth games and technologies of the self are not acted out alone; they play out in relationships. Foote and Frank (1999) explore these ideas as they relate to grief and bereavement, conceptualizing grief as a personal problem to be overcome. Therefore, “clinical responses to bereavement (whether individual psychotherapy, group counselling, or workshop) take on a metaphor of ‘grief work’” (p. 167). The practitioner frames the bereavement role as temporary, and they are professionally entitled to intervene in grief, principally by demarcating what is appropriate and what is pathological (Foote & Frank, 1999). I see immense parallels here with the way fat bodies are disciplined and guided within therapeutic sessions, and the way clinical practitioners engage in what I am terming “body work”.

The “body work” taken on in therapy with fat clients harkens back to what fat activists discussed about how the fat body is only allowed to exist on the way to being thin (Cooper, 1997; Friedman, 2012; Kent, 2001; Mik-Meyer, 2010). Dominant clinical understandings would frame work done with clients to accept their body as is and to not engage in thinness-focused

body work as inappropriate. Therapeutic relationships and body work involve an overt or covert struggle over power, resources, and affirming identities. “This struggle may be very calm and easily negotiated between two people in banal, everyday conversation, or it may bubble more explicitly to the surface as people challenge the way they are spoken to or about by others, the opportunities provided to or denied them” (Baines, 2011, p. 6). Every action undertaken in the therapeutic relationship is political. Therapeutic interactions that subscribe to dominant discursive constructions of bodies, reinforce deviance, and prescribe weight loss are “ultimately about power, resources, and who has the right and opportunity to feel positive about themselves, their identities, and their futures” (Baines, 2011, p. 6).

Margolin (1997) focuses on the cognitive dissonance required for therapists to be enacting power relations on clients, while remaining unaware of their use of power. Power is constantly being enacted in ways that therapists describe, discuss, and treat their clients. “When social work describes its clients one way, all the other infinite ways those clients could be described are excluded. When social work establishes one reality, it necessarily blocks others...” (Margolin, 1997, p. 7). Often the reality that is being blocked is that social workers and therapists are conduits for broader societal and state expectations.

Social Work and the State

Social work is a profession that transmits dominant societal expectations to citizens. Parton (1999) conceptualizes social work as “developed at a midway point between individual initiative and the all-encompassing state” (p. 110). Margolin (1997) believes that the social work profession makes it possible to enact political surveillance to keep track of marginal people as they pursue personal activities. Epstein (1999) voices suspicion about therapy and the social work profession, stating:

The profession of social work...invariably includes attributes of caring, treating, and protecting. Its image is benevolent, its function to administer help to those in need. Through mental healing, social work entrenches in society generalized standards of personal conduct and subjective states. At the same time, it honors self-determination and individual autonomy. There is uncertainty about its aims partly because numerous stratagems conceal its power to shape and control thought and behavior (p. 3).

Epstein (1999) explores how the social work profession consistently tries to counter being perceived as feminine with subscribing to “gender-neutral, rational social science” (p. 4). Bates (2011) argues that rational decision making and reliance on the “evidence” ignores important contextual information and limits available decisions. Social workers subscribe to positivist, clinical knowledge, and often use such knowledge to re-marginalize our clients. The social work profession is a major instrument through which the state governs and provides for the welfare of its citizens (Epstein, 1999). Social workers manage the population based on dominant state discourses. “...social work must dominate its clients, although in theory and in its manner of interpersonal relations with clients it puts forward a democratic egalitarian manner. However, to be effective, to show results, it must influence people, motivate them to adopt the normative views inherent in the intentions of social work practice” (Epstein, 1999, p. 8). Social workers often work on interdisciplinary health teams where the normative views of the medical model and dominant societal discourses come to bear on the work they do with clients. As doctors pressure patients to become thinner, social workers often follow suit as part of a team initiative to combat “obesity” and the assumed associated dangers.

Margolin (1997) draws parallels between the rise of social work and the rise of public health. Public health became a justification for “all kinds of inspections, home visiting,

monitoring, and registration...” (p. 13). Margolin argues that both professions stabilize and entrench class power by focusing primarily on the poor. “The very existence of poverty was treated as questionable, a possible ruse, requiring the most cynical, minute investigation...” (p. 20). Fatness and poverty are linked, and it follows that social workers would also investigate fatness in a similar manner (Ernsberger, 2009). Social workers use sympathy and friendship to investigate while “convincing the observed that surveillance is not occurring” (Margolin, 1997, p. 25). Because social workers cannot carry out investigations if they perceive themselves as deceptive and manipulative, they have to genuinely convince themselves that they are “doing good” (p. 65). Social workers must believe that they are responding to real needs and actually helping clients (p. 65).

Because social workers are required to see themselves as doing good instead of seeing themselves as deceptive or manipulative, they induce clients submission to governmental authority “not by threats or warnings, but...by earnestly cheering them on, by motivating them to see things differently, by asking them to change their attitudes” (Margolin, 1997, p. 73). This puts the focus on bad attitudes rather than a bad system. Anti-oppressive practice is a way to acknowledge and challenge the system as practitioners work individually with clients.

Oppression and Anti-oppressive Practice

My theoretical framework is informed by understandings of oppression and anti-oppressive practice (AOP). Baines (2011) defines oppression as taking place when:

...a person acts or a policy is enacted unjustly against an individual (or group) because of their affiliation to a specific group. This includes depriving people of a way to make a fair living, to participate in all aspects of social life, or to experience basic freedoms and human rights. It also includes imposing belief systems, values, laws, and ways of life on

other groups through peaceful or violent means. Oppression can be external...or internal, when groups start to believe and act as if the dominant belief system, values, and way of life are the best and exclusive reality. Internal oppression often involves self-hate, self-censorship, shame, and the disowning of individual and cultural realities. (p. 2)

I argue that people, policies, systems, and structures are oppressive towards fat bodies. Fat people suffer both from internal and external oppression. Macro and micro social relations generate oppression. Macro-level social relations include social structures, social forces, and social processes such as capitalism, governments and their policies, religious and cultural institutions, international trade and financial bodies (Baines, 2011). Fat-specific examples of macro-level relations include government “obesity fighting” initiatives, a culturally entrenched weight-loss movement (which is also tied to extremely high financial revenue), fat people being denied access to in vitro fertilization and banned from adoption opportunities, and insurance companies refusing health coverage to fat people.

Micro-level social relations include social norms, everyday practices, workplace specific policies, values, identities, and so-called common-sense (Baines, 2011). Examples here include, the common-sense idea that fat is unhealthy, the celebrated identities of people who are heavily involved in personal fitness, the norm of most clothing stores only going up to a size 12, etc. Many acts of oppression at a personal level occur as aversive behaviour that emerges in everyday interactions between people (Mullay, 2002). These actions can include avoiding eye contact, increasing physical distance, using gestures of defense and aversion, negative speech and tones of voice (Mullaly, 2002). Participants speak extensively about aversive behaviour in Chapter Four. It is important for practitioners to work towards resisting and changing micro relations. “Using the term ‘social relations’ highlights that these relations are organized and operated by

people and can be halted or reorganized by them as well...they are not inevitable conditions of modern life or ones that we cannot change” (Baines, 2011, p. 5).

Anti-oppressive practice is an umbrella term for social justice-oriented approach to social work theory and practice. It draws on feminist, Marxist, postmodernist, Indigenous, poststructuralist, critical constructionist, anti-colonial, and anti-racist approaches (Baines, 2011). “These approaches draw on social activism and collective organizing as well as a sense that social services can and should be provided in ways that integrate liberatory understandings of social problems and human behaviour” (Baines, 2011, p. 3). Baines (2011) states that anti-oppressive practitioners seek to transform social relations through “direct practices that incorporate liberatory approaches within specific interventions and interactions, as well as through larger actions aimed at structural or macro-level change such as activism, scholarly work, resistance, advocacy, collective organizing, mass actions, and long- and short-term mobilization of individuals, groups, and societies” (p. 4).

Reflexivity is an important piece of anti-oppressive practice. “It involves reflecting not only on one’s own practice, social location, and power but also on the practice, social location, and power of others and on larger social processes and dynamics, in order to strengthen one’s anti-oppressive capacity, social analysis and critique, and overall...practice” (Baines, 2011, p. 196). Social problems are individualized and depoliticized by giving them medical or psychiatric diagnoses. Therapists have an obligation to be reflexive and incorporate an understanding of macro relations and oppressions into their practice, rather than uncritically embracing the power to diagnose or define others (Baines, 2011). Thoughtful critique and skepticism are important reflexive practices.

Being reflexive about intersectionality and positionality is fundamental to AOP. Therapists need an intersectional approach to fatness. Webhi (2011) argues that social workers must also “adopt an anti-colonial stance in recognition of historical and contemporary North/South power imbalances that continue to shape social work practice” (p. 134). Fatness is closely associated with racialized populations and poverty and therapists need to consider intersecting forms of oppression that shape the fat experience (Ernsberger, 2009). Therapists need to work to avoid perpetuating neocolonial discourses and practices when working with marginalized clients (Webhi, 2011). Webhi states,

As a social worker, I am charged with the task of continually asking myself questions related to who I am in relation to the community I am working with: Am I an insider, outsider, expert? Do I own my privilege? Do I understand the complexity of my social location and its impact on my work? How did I come to this work? We need to move beyond simplistic dichotomies in answering these questions (Abu Lughod 1991; Absolon and Herbert 1997; Narayan 2003). Specifically, we need to recognize the complexity of our social locations and how these position us within particular contexts. Therefore, instead of seeing ourselves as insiders or outsiders, experts or novices, the authors argue for the need to see that we are always “in relation” (p. 142).

We must recognize the heterogeneity of communities (differences within and between them), as well as how these same communities are located within a broader web of power relations (Webhi, 2011). It is important to note that fatness has no “fixed identity”, fat people can be both oppressors and oppressed depending on a variety of factors (Mullaly, 2002). When we consider the marginalization of fat people, we must not consider fatness or the marginalization of fat bodies to be static concepts. The fat experience is dynamic and relational. Though the focus of

this dissertation is on fatphobia and therapy, it is overly simplistic to present fat oppression as being based solely on fatness. Fatness is not a singular group characteristic, although all fat people may be oppressed in some ways, there is a great diversity among fat people that will result in more or less oppression. An anti-oppressive practitioner will be able to bring other aspects of positionality into discussions of fatness. AOP doesn't shy away from complex social realities.

AOP is constantly changing, refining, and growing to address emerging tensions, struggles, social problems, and structural factors (Baines, 2011). The “war on obesity” and associated entrenched fatphobia should be understood by practitioners through an AOP lens. Anti-oppressive practitioners have an obligation to “help clients, communities, and themselves to understand that their problems are linked to social inequality” (Baines, 2011, p. 4). All therapists should be working to alleviate clients' emotional pain and immediate difficulties that arise from moving through the world in a fat body, while simultaneously understanding and working to challenge the larger fatphobic forces that generate inequity, unfairness, and social injustice. (Baines, 2011).

Politicizing Fat in Therapeutic Practice

Therapists must be critical of our profession and ourselves, aware of the power relations inherent in our profession's history and in the work that we continue to try to do. Therapists need to have a critical and reflexive understanding of fatness and our own reactions to fatness, especially since we work alongside so many of the public health efforts to combat obesity. Social workers, psychiatrists, and psychologists work in a variety of health care settings where fatness is seen as something that needs to be eradicated. This singular goal removes subjectivity and relativity, eliminating tensions and debates as well as the need or space for reflexivity (Webb 2001).

“When social workers look only for certain information, the risk of compartmentalizing clients’ experiences (or worse yet, objectifying them) is very real” (Bates, 2011, p. 158). Embracing dominant understandings of obesity “suggests an alliance with science and a weakening of an alliance with clients, as a result jeopardizing our capacity to build trusting relationships with them” (Bates, 2011, p. 158). Our profession is used as a tool in the war against obesity, and many therapists do not think critically about this “fight”. Therapists are likely to see service users who are fat no matter what area of social work we practice in, and we all likely have our own body histories and struggles that influence the way we approach fatness. “We lose an invaluable source of information when we fail to use our own insights, frustrations, disappointments, and successes as entry points into improving theory and practice” (Baines, 2011, p. 7). Engaging in reflexivity will enable therapists to approach body work in an anti-oppressive manner. We must equip ourselves to think critically about body size.

“When an issue is politicized rather than just thought of as an unfortunate social problem or individual shortcoming, individuals and groups can more easily analyze and act upon it” (Baines, 2011, p. 6). There is a need for therapists to begin to politicize fatness and begin questioning and developing new understandings of body size that we can bring into our theories and practice. It is important to question “who benefits from the way things operate at any given point in time, who can help make the changes we want, how we can help ourselves and others see the many ways in which issues are political, and how multiple strands of power are operating in any given scenario” (Baines, 2011, p. 6). Therapists also have an ethical obligation to shift the individualized blame and shame away from fat clients and communities. We need to assist people with situating their bodily experiences within wider oppressive systems. Fat people often internalize what they see as their individual failure to be thin and accept the stigma and

discrimination they experience as their fault. It can be extremely transformative to expose people to the fat activism and fat acceptance movements through online media, blogs, artistic means, photos, and social activism events. Therapists have an obligation to be well versed in these kinds of resources and able to explore them critically with clients. Oppressive social relations are enacted by therapists, but they can also be changed by therapists. Therapists theoretical and practical development needs to be based on the struggles of marginalized people (Baines, 2011). Practitioners need to remember this as they consider how to approach issues of body size within the context of their work. Beyond individual practice, therapists also need to realize that they need allies to resolve underlying social, economic, and political issues (Baines, 2011). Therapists must organize and mobilize with fat activists, fat academics, and the fat acceptance movement to push for transformative change.

Conclusion

I hope to promote a critical understanding of fatness in this dissertation. I see a critical understanding of fatness as one that does not take all the “obesity epidemic” panic at face value. A critical understanding sees obesity as something that is socially constructed. A critical understanding of fatness goes deeper to bring forth the complexity of intersectionality and historical and contemporary micro and macro forces. Many of my research participants felt that their therapists were not listening to them about their experiences of weight stigma and weight-based oppression. Client experience is “a key starting point in the development of new theory and knowledge, as well as political strategies and resistance. Their voices must be part of every program, policy, planning effort, and evaluation” (Baines, 2011, p. 7). A critical understanding of fatness sees fat people as human beings, and brings forth our voices and experiences into a discussion that somehow manages to both revolve around us and exclude us at the same time.

CHAPTER THREE: RESEARCH METHODS

Among the research on fatness that is available, there is a trend towards methodological choices that do not center the lived experience of fat people. Fat people are reduced to statistics to be studied and problems to be solved, their stories are rarely present. This trend strips fat people of their voice, denying agency and opportunities for resistance and challenge. Research studying fat issues should bring forward the voices of fat people.

There is a stark difference between methodological approaches in Fat Studies, and primary research that is done about obesity and health. Fat studies is “an interdisciplinary field of intellectual inquiry” (Wann, 2009, p. ix). Fat scholars analyze and explore weight discrimination and the realities of the fat experience. Fat scholars challenge the idea that fat bodies are unattractive, diseased, or not capable. Fat Studies research is primarily secondary research, looking at other sources and unearthing insidious examples of weight bias. Fat scholars often rely on Foucauldian discourse analysis or feminist inquiry to show how power influences the experiences of bodies that are considered deviant. Primary research about obesity is often done from the dominant viewpoint that fat bodies are a problem that need to be fixed. There often isn’t a fat liberationist or body political viewpoint found in primary research, even if these studies are looking at weight stigma. If fat peoples’ experiences of marginalization are not the focus, it is hard to use the findings for any sort of social change, as the studies reinforce that fat people are “Other”.

Almost all primary research about “obesity” is published in medical, psychological, or health-related journals (Agell & Rothblum, 1991; Baum & Ford, 2004; Cramer & Steinwert, 1994; Davison & Birch, 2001; Drury & Louis, 2002; Eaton et al., 2003; Hebl & Xu, 2001; Latner

& Stunkard, 2003; Myers & Rosen, 1999; Robinson, Bacon, & O'Reilly, 1993; Schwartz et al., 2003). Even though most of these studies were looking at stigmatization and discriminatory attitudes, they were situated firmly within a positivist paradigm. The researchers did not locate themselves in any of the studies, they were merely reporters on the phenomenon of weight discrimination or fatphobia. Though the studies measured stigma, they still begin from the premise that fatness is a medical condition, a disease, or a pathology.

Many of the studies sought to measure discriminatory attitudes towards overweight and obese individuals, rather than doing qualitative research with fat people about their own experiences of discrimination (Agell & Rothblum, 1991; Cramer & Steinwert, 1998; Hebl & Xu, 2001; Larkin & Pines, 1979; Latner & Stunkard, 2003; Robinson, Bacon, & O'Reilly, 1993; Schwartz et al., 2003). The few examples of research that explore fat people and their experiences mostly utilize fixed-choice questionnaires (Davison & Birch, 2001; Drury & Louis, 2002; Myers & Rosen, 1999). This method misses the complexity and intersectionality of fat stigma, as respondents cannot elaborate on the answers (Cicourel, 1964). However, these methods do demonstrate that fat stigma exists, and findings from these "objective" studies are often taken more seriously than qualitative fat research.

The methodologies in the studies were assumed to be neutral, there was no discussion about what assumptions were already made by using such methods. For example, Latner & Stunkard (2003) presented participants with 6 drawings, 1 "healthy" child, 4 children with various different disabilities, and 1 obese child. Participants were asked to rank the drawings in order of preference (Latner & Stunkard, 2003). The researchers stated that the drawings were matched for height, facial appearance, and clothing, and that the drawings depicted White children (Latner & Stunkard, 2003). However, there was no example of how the obese child was

drawn, children with invisible disabilities were not acknowledged, and there was no intersectional analysis about how the results may have changed had the drawings not been of White children. I also felt that the structure of the study did nothing to combat ableism or fatphobia. Yet the drawings were just assumed to be a neutral tool used in the measurement of attitudes towards “obese” children.

None of the studies were action or social justice oriented. Most of the studies measured discriminatory attitudes and concluded with discussing the findings. Only two studies actually made recommendations to combat fat stigma (Cramer & Steinwert, 1998; Drury & Louis, 2002). Cramer & Steinwert (1998) suggested that there needs to be a diversity of body types represented positively in the media, children’s books, and movies. They point out that fat bodies are typically associated with “ugly” characters or villains, and that this needs to change. I agree that this is a good starting point to reduce abjection. Drury & Lewis (2002) urge clinicians to be “acutely aware of their own biases related to weight, and moreover, to recognize when a client is at-risk not to return for health care” (p. 559). Being aware of biases and how they impact health care access is fundamental for health care practitioners. Though all the studies measure and demonstrate how fat people are marginalized, most were not undertaken to challenge the status quo. The research did not attempt to shift power relations or dismantle privilege, it was not interested in making fat people any less marginalized.

Many studies focusing on fatness and health care issues were influential when I was considering my own research. Primary health care practitioners often display significant anti-fat bias (Agell & Rothblum, 1991; Drury & Louis, 2002; Hebl & Xu, 2001; Myers & Rosen, 1999; Schwartz et al., 2003). Physicians and other health care professionals, even those who specialize in “obesity” believe that fat patients are lazy, stupid, and not worth helping, subsequently

spending less time with them (Hebl & Xu, 2001; Schwartz et al., 2003). Physicians are also more likely to recommend counselling to heavier individuals, suggesting a belief that overweight patients are unhappy and unstable (Hebl & Xu, 2001). People with higher BMIs have many experiences with being misdiagnosed or not diagnosed at all because medical professionals assume that the only explanation for their symptoms is their weight (Harding & Kirby, 2009). Physicians indicated that they would prescribe more weight-related tests for obese patients, regardless of what their symptoms were (Hebl & Xu, 2001).

Drury & Louis (2002) found that the fatter a person gets, the more they delay or avoid going to the doctor. Frequently experiencing stigmatizing situations is associated with more mental health symptoms, more negative body image, and more negative self-esteem (Myers & Rosen, 1999). However, despite these studies, poor health in fat people is more commonly discursively constructed as an individual problem and an individual failure. Fat people are blamed and stereotyped for their poor health, and the broader barriers to health care and consequences of fat stigma are rarely addressed.

These studies made me consider the stigma that fat people might also experience at the hands of mental health care practitioners, including psychiatrists, psychologists, social workers, and psychotherapists. The “helping professions” are slow to acknowledge that fat stigma and weight discrimination are issues that might affect common practices and client experiences.

Scholars following in post-structural and Foucauldian traditions often choose to analyze text (Abel, 2014; Boero, 2007; Heyes, 2006; Holmes, 2009; Saguy, 2013). These studies focus on the naturalized assumptions of truth upon which the “obesity epidemic” is constructed. Many focus on media constructions of obesity, as the media transmits dominant cultural messages, images, or products that define reality in ways that both privilege and marginalize (Mullaly,

2002). Over the past several decades, the media has exponentially increased their coverage about obesity, bringing it to the forefront of public consciousness (Wann, 2009).

Though textual analyses are important, they do not bring fat experiences to the forefront. The nearly exclusive focus on text is problematic when studying non-hierarchical systems of power (Moon, 2004). The printed text already bears the mark of hierarchy and leaves out those whose experiences are not preserved in text. When members of subordinated groups do not find themselves reflected in literature, the media, and formal education, or are represented in a highly distorted fashion, they are rendered invisible by the dominant group that is also marking them as different (Mullaly, 2002). Though textual and discursive analysis makes important contributions to Fat Studies by demonstrating the tactics and discursive underpinnings of the “war on obesity”, other methods are more suited for representing fat people.

When conceptualizing my research, I looked to Boero (2012), a scholar whose research studied fat people attending weight-loss programs. Her stance was that the impact of the public policy and media attention on the “obesity epidemic” could best be understood by focusing on the experiences of fat people attempting to lose weight. To adequately and thoughtfully represent their complex experiences, Boero (2012) used a mixed-methods approach. She conducted participant observation by joining a 12-week Weight Watchers course and attending 22 Overeaters Anonymous meetings. Boero (2012) also observed Weight Watchers and Overeaters Anonymous online listservs. She conducted in-depth, semi-structured interviews with Weight Watchers and Overeaters Anonymous members. She included a textual analysis of Weight Watchers and Overeaters Anonymous literature, including posters, pamphlets, and websites. “Bringing these methods together provides a context for the epidemic and a depth of analysis that any one alone could not have achieved” (Boero, 2012, p. 140). Boero (2012) brought a

gendered lens to her work and complicated previous feminist literature that asserted that all diet programs were the same (Bordo, 1993; Chernin, 1994; Spitzak, 1990). Her seamless blend of ethnographic description, interviewee quotes, and textual analysis allowed the reader to imagine what it is like to be a participant in a weight-loss program. I decided to also use a mixed methods approach, using visual data and narrative inquiry to explore the experiences of fat people who are accessing counselling or therapy. I wanted to broaden understandings of how stigma impacts fat people's lives and have visual representations of experiences or objects that participants felt were meaningful. I also sought to understand how the silence around body size in social work or therapeutic education impacts the client when issues around weight come up in therapy.

Narrative inquiry is a way for participants to make sense of their bodily experiences, construct the self, and create and communicate meaning (Chase, 2005). I conducted 16 semi-structured narrative interviews. Participants were asked to bring in 1-3 photos or objects that they felt were important to their relationship with their body. Using photos to represent experience can be "particularly powerful...for...people with socially stigmatized health conditions or status (Wang & Burris, 1997, p. 370). Fatness is considered a health issue and fat people experience the negative consequences of social stigma in every area of their lives. The objects brought to the interviews guided discussion about cultural norms and social interactions.

Using photos, objects, and interviews allowed me to both uncover and highlight underlying and insidious cultural assumptions about fatness and focus on a specific arena (therapy) where these assumptions have effects. Fat discourses are often intertwined with dominant discourses about health. Discourses on health emerge and gain widespread acceptance when they are in line with the dominant sociopolitical context in which they are produced (Poole, 2007). The ways that we speak about health are never about health alone (Poole, 2007). Health is

attached to other interests and “professional, economic, political, cultural, and ideological” agendas (Robertson, 1998, in Poole, 2007, p. vii). Health discourses are reflexive categories, principles of classification, normative rules, and institutionalized types (Foucault, 1972).

Beyond standard research documentation, the methods chosen for this dissertation also provide an opportunity for ongoing embodied and encultured knowledge transfer (Blackler, 1995). This dissertation aims to disseminate the photos and objects participants brought to both academic and non-academic audiences. The photos will not just provide representation, they will be a form of activism. Activist art has “one foot in the art world and the other in the world of political activism and community organizing” (Felshin, 1995, p. 9). The photos are easily interpreted by a variety of audiences, allowing people from different walks of life to identify with facets of the work (Barone, 2008). The data will be used to raise awareness through workshops, lectures, focus groups, photo exhibits, and other methods of dissemination. This research is an important step for fat activists in Canada.

Recruitment

Using non-random purposive sampling mitigated and supplemented by snowball sampling, I recruited 16 participants who participate in the Facebook groups Fat Awesome and Queer (FAQ), Fat Babes Society, Fat Friends, Fat Activists, Fat Fitness and Well-Being, and Curvy Palz. Most of these groups’ community guidelines are explicit about providing anti-oppressive spaces where members are expected to be intentional about unpacking fatphobia. Curvy Palz is a group for swapping plus-size clothes, I included it because it is an extremely active group where participants have a diversity of viewpoints around fatness. I sought participants from these groups because I hoped to find people who were already comfortable engaging in online spaces for bigger bodies, and therefore would be comfortable discussing their bodily experiences in an

interview. Though experiences of fatness are intersectional and unique, I hoped to find people who would be able to recognize and name the ways that both individual and structural barriers had impacted their experiences in their body and their experiences in therapy. I also publicly posted my recruitment poster on my personal Facebook, where it was shared 20 times by people in Fat Studies, the broader academic community, and people in the fat activist community. I reached out privately via email to a few key figures in the Toronto fat activist community and my dissertation committee, asking them to share my recruitment poster widely. I recruited from July 2019 to November 2019, reposting the poster and scheduling and conducting interviews as participants reached out. I had one person reach out who was not fat, but who had been in therapy for eating disorders where their body and weight had come up. I did not conduct an interview with this person because I was specifically looking for people who had experience moving through the world in a fat body. Many people also reached out but ceased contact before an interview could be scheduled. There could be several reasons for this. People who were interested may have ultimately decided that talking about their body history or experiences in therapy would be too painful. Many of the interviews I did were very emotional and difficult experiences for participants. I also did not specifically identify myself as a fat person on the recruitment poster, so the fat communities I accessed might have been understandably suspicious of outsider research or even how insider research was going to be framed, as most research on fatness does not use a social justice lens and is not emancipatory for fat people.

When people reached out to my research email, I informed them that the interview would take approximately 1.5 hours and that I would provide them with a \$20 Tim Hortons gift card to thank them for their time. I explained that the interview would first explore their history and relationship with their body more generally, and then explore how their bodies and body history

had come up in therapy. I requested that participants bring 1-3 objects to their interview that were or are important to their relationship with their body (photos, books, clothing etc.) so that I could get a richer sense of their history. Participants consented to have the photos and objects shown in this dissertation in their entirety, declining to exclude them or to have identifying details blurred. Participants understood that this would compromise anonymity but felt strongly that they wanted a visual record of what they brought to the interview included in this research.

Interviews

I conducted semi-structured interviews. I explained that the interview was broken up into two parts, their body history and their experiences in therapy. I had a list of questions, but where possible I gave the participants the opportunity to tell me their story and history in their own words, and they often covered several of my listed questions in one story. In each interview I was flexible and respondent to participant needs and stated themes. I asked follow-up questions based on the stories and answers they provided.

Fat Experience

1. Tell me about your relationship with your body.
2. What descriptors do you use for your body? How do these descriptors make you feel?
3. What messages do you receive about your body?
4. Are there particular spaces where you feel you get a lot of feedback about your body (either positive or negative)?

Objects

5. Tell me about the objects that you brought to this interview. Why are they important to you? What made you choose them?
6. Have your feelings about these images/objects remained consistent?

Therapy Experiences

7. Do you feel your body has impacted your ability to access therapy, mental health services, or social services?

8. Do you currently see a social worker, counsellor, or therapist? How frequently do you see them OR when was the last time you saw one?
9. Do you know the credentials of your current or past therapists?
10. How do you feel about the physical space of your therapist's office? Is it accessible for you?
11. Do you feel that your body size has influenced your interactions with your social worker/counsellor/therapist? How?
12. How did your social worker/counsellor/therapist respond to your body? How did that make you feel?
13. Do you discuss your body and weight in counselling sessions? Why or why not?
14. If you do, how do those discussions about your body size and/or weight go? If not well, did you stay with the therapist? Why or why not?
15. Do you feel social work or counselling services meet your needs? In what ways? In what ways do they fall short?
16. Does your therapist take a more structural or individual approach when discussing body topics?
17. What is the best way for a therapist to approach discussions about body size with clients?

Prior to the interview I gave participants a list of counselling and trauma resources that they could contact if they were feeling distressed. After the interview I also checked in and did some debriefing if necessary. Many participants expressed that even though it was hard to talk about experiences of fatphobia and trauma related to body size, they felt it was important information that they wanted to share to contribute to the research and a growing body of knowledge about fatness.

Analysis

I analyzed interview transcripts and the items participants brought using thematic analysis as outlined by Braun & Clarke (2006). They argue that thematic analysis should be considered a method in its own right, rather than performed within other analytic traditions (Braun & Clarke, 2006). "Through its theoretical freedom, thematic analysis provides a flexible and useful

research tool, which can...provide a rich and detailed, yet complex, account of data” (Braun & Clarke, 2006). “Thematic analysis is a method for identifying, analyzing and reporting patterns (themes) within data” (Braun & Clarke, 2006, p. 80). The researcher has an active role to play in identifying patterns/themes, selecting which are of interest, and reporting them to the readers, themes do not simply “emerge” from the data (Taylor & Ussher, 2001). I used a constructionist method, examining the ways that events, realities, meanings, and experiences discussed by participants are impacted by broader fatphobic and health-based discourses operating in society.

My analysis was driven by my own theoretical, practical, and analytic interest in how fatphobia impacts the therapeutic relationship. “Research from the margins is not research on the marginalized but research by, for, and with them/us” (Brown & Strega, 2005, p. 7). I felt that I was in a unique position to carry out this research as a fat social worker who also sees her own therapist. I feel an imperative to discuss the impact of fatphobic dominant narratives on how therapy is practiced, and how clients interpret their bodies becoming part of a therapeutic space, and I come at these ideas from personal, professional, and academic experience.

I coded my themes based on how they related to the original research questions and the assumptions that were informing my research. My research questions were: “How does fatphobia influence participants’ lives?” and “How do bodies and body size come up in the context of a therapeutic relationship?” As a big part of how we approach body discussions in a variety of arenas is determined by our historical relationship with our body, I also focused on participants’ body stories from other areas of their lives to better understand what history was coming to bear on the therapeutic relationship. My thematic analysis selected themes from the data based on their ability to “capture something important in relation to the overall research question” (Braun & Clarke, 2006, p 82).

Braun & Clarke (2006) argue that researchers must make their (epistemological and other) assumptions explicit. "...be clear about what they are doing and why, and to include the often omitted 'how' they did their analysis" (Braun & Clarke, 2006, p.79). I approached the research grounded in a feminist theoretical approach. The following assumptions informed my analysis of the data:

1. Fatphobia is a legitimate form of oppression
2. Fatphobia influences our understandings of mental and physical health
3. Fatphobia permeates the therapeutic relationship

I had an additional assumption approaching the research that most participants would have a negative experience in therapy because of their body size, but when I started to code the data, that turned out to not be an entirely accurate assumption, as I will discuss further in Chapter Seven.

I followed Braun & Clarke's (2006) steps for doing a thematic analysis. I began by reviewing my transcripts for accuracy, I then began to code the data, giving each item equal attention throughout the coding process. This was my initial list of codes:

Codes	
Adaptive Item	Fat Therapist
Advice For Therapists	Important Clothes
Affirming Therapist	Making Weight The Problem: Doctors
Body Descriptors	Making Weight The Problem: Therapists
Chronic Illness/Disability	Mind/Body Separation
Clothes	Performance
Cost	Positive Body Messages
Credentials	Psychiatry
Dating/Relationships	Public Space
Dieting/Disordered Eating	Queerness
Doing What I Want In The Body I Have	Race
Eating Disorders	Shame
Educating Therapists	Silence/Absence
Family	Space Accessibility
Fat Community	Therapist Availability
	Work

Figure 1. Codes

I started considering potential themes based on the entirety of the data set. I compared themes to each other and back against the original data set to make sure they were consistent and distinctive from each other. If they were not distinctive, I grouped similar codes together. I sought to analyze and interpret the data in the context of broader fat studies and feminist scholarship, rather than just describing what my participants said. I took my time with every part of the process, immersing myself in the data, giving it close readings, rather than rushing or skimming. I recognized that I was active in the process of choosing themes, they did not merely ‘emerge’ from the data. I was guided by my research question, as well as my dual position as a reporter on and member of the community about which I am speaking. I started grouping codes into themes, creating the following map which led to the body chapters of this dissertation:

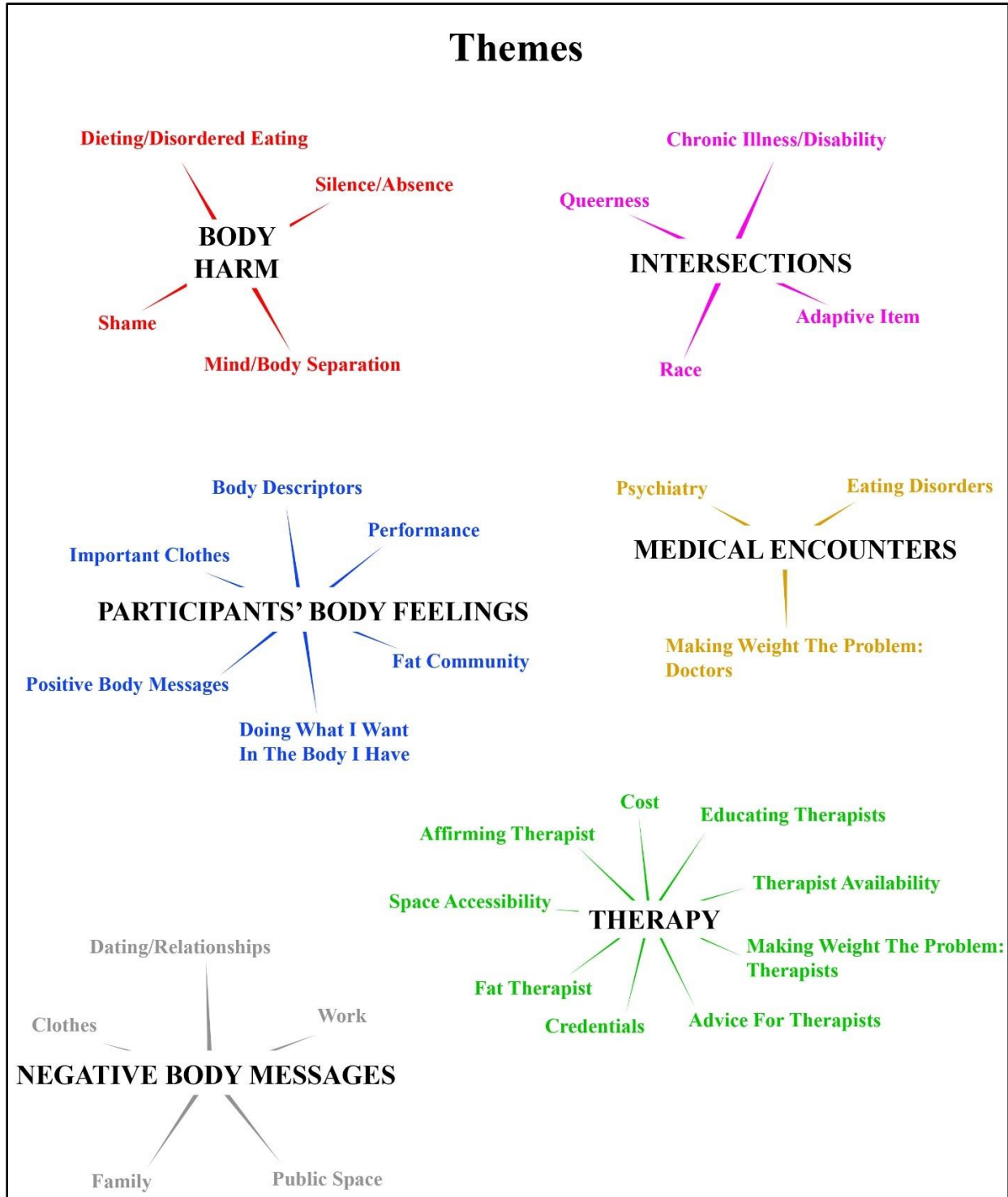


Figure 2. Theme Map

Demographics

AGE	GENDER	SEXUAL ORIENTATION	RACIAL/ ETHNIC IDENTITY	ANNUAL INCOME	BMI
27	Fluid and Non-existent (femme presenting)	Pansexual, with inclusion of trans* identities	White	41000-50000	Obese
29	Cis-Woman	Bisexual	Biracial, Black & White	51000-70000	Obese
30	Female	Bi	Caucasian	51000-70000	Obese
31	Cisgender Male	Cisgender Gay Man	South Asian	Fluctuates 21000-70000	Normal
31	Femme-ish, Butch-ish, LADY BEAR	Queer	White/ Jewish/ Polish	51000-70000	Obese
32	Female*?	Pansexual*?	White	51000-70000	Obese
32	Genderfluid/non-binary/femme	Bisexual	White	41000-50000	Overweight
34	Enby Femme	Queer/ Bisexual	White	Chose not to answer	Obese
35	Woman	Queer	White	41000-50000	Obese
35	Femme Queer Ciswoman	Queer	Mixed-Race Sri Lankan and British	Less than 20000	Obese
36	Queer	Queer	Caucasian	51000-70000	Obese
42	Female	Straight	South Asian	70000-100000	Overweight
42	Woman	Queer	White	70000-100000	Obese
44	Femme/Gender Neutral	Queer	White Jew	31000-40000	Obese
44	Nonbinary She/Her	Queer	Caucasian	51000-70000	Obese
47	Cis Female	Queer	White	70000-100000	Obese

Figure 3. Demographic Chart



Figure 4. Body Words Cloud

Prior to the start of the interview, I provided participants with a demographic form that asked participants for their age, gender, sexual orientation, racial and ethnic identity, annual income, BMI, and words that they used to describe their body. Participants were informed that they could skip any questions that they did not want to answer. Participants ranged in age from 27 to 47. Participants generally had higher incomes, one participant reported making below \$20,000, but

most participants made \$41,000-\$70,000. 13 participants stated that their Body Mass Index (BMI) was “Obese”, two participants identified their BMI as “Overweight”, and one participant had lost weight due to cosmetic procedures and a severe eating disorder and now identified their BMI as “Normal”. Participants used a large diversity of words to describe their bodies, with the majority of participants using the word “Fat”; “Strong”, “Curvy”, and “Soft” were also used by many participants. A few participants stated that their bodies were “a work in progress” or had “room for improvement”. Other participants were more positive, describing their bodies as “Glorious”, “Resplendent”, “Graceful”, and “Accomplished”.

“Fat activism is a particularly “queer-flavoured” movement” (Hill, 2009, p. 1). Queer people bring the language and identity politics of their communities into fat activism, in order to claim fatness as an empowering and subversive political identity (Hill, 2009). This was reflected in the gender and sexuality demographics of my participants. Eight participants identified their gender as gender neutral, gender fluid, non-binary, femme, or queer. Seven participants identified as women, female, or cisgender woman/female. One participant identified as a cisgender man. Almost all participants were queer. Nine participants identified as queer, four participants identified as bisexual, two identified as pansexual, and one identified as gay. Only one participant identified as straight.

Ten participants identified as White or Caucasian, two identified as White and Jewish, two identified as mixed-race (Sri Lankan and British) and biracial (Black and White), and two identified as South Asian. Even though people of colour are disproportionately affected by fatphobia, I struggled to find people of colour who were willing to participate in this study (Campos, 2004; Ernsberger, 2009). This may have been because even though I am mixed-race, I am White-passing and perhaps potential participants didn’t want to speak to someone who they

were reading as White. It may also speak to critiques that Fat Acceptance is an overly White movement. “As a field, fat studies has long been a bastion of whiteness” (Pausé, 2019, p. 7). Perhaps the social uptake of fat acceptance mirrors the Whiteness of Fat Studies. I recruited in online spaces where many of the most frequent posters appeared to be White. I did specifically reach out to fat folks of colour who I knew both within and outside of academia to pass my poster on, but still ended up with only a quarter of participants being people of colour.

Limitations

Due to a small sample size and the use of purposive sampling, these findings cannot be generalized to all fat people. My purpose was to conduct exploratory qualitative research to gain an in-depth understanding of participants’ body histories and how those histories came to bear on their experiences in therapy. This study was not seeking to determine population norms or to be able to suggest that fat peoples’ experiences are homogenous enough to be generalized.

It is a limitation that the majority of participants in this study identified as White. This is problematic due to the limited scholarship on fatness and race that exists. Most of the scholarship around fatness and race has also been written by White people (Pausé, 2019). It is also a limitation that participants self-reported their BMI, so that demographic marker may not be accurate. However, as discussed in prior literature, I do not feel that the BMI is a legitimate or accurate measure of size or health as it does not take into the complexity of human experience even as it is the main marker by which we categorize bodies.

CHAPTER FOUR: SOCIALIZING THE FAT BODY

The worth of my body is contingent upon its size. Worth meaning...things like how attractive it is, how healthy it is, how desirable it is, how useful it is...I get that message from mostly everybody all of the time. Parents growing up, peers, family, partners, strangers, doctors of course, co-workers, it's kind of universal.

- Diane*

It's almost like a ... Well, it is structural. It's like a shared, social understanding. I know people are going to think horrible things about me or say horrible things to me or do horrible things to me, and that's just life in a fat body.

- Shira

Fat bodies are framed as a significant departure from a “normal” physical body, and people react to fat bodies in accordance with that belief. Dominant discourses support the creation of a universal subject through capitalist ideals, language, and abjection. The neutral body assumed by the neoliberal state is a White, able-bodied, middle-class, heterosexual, masculine body (Cooper, 1997; Gatens, 1996). This universal subject reflects fantasies about the value and capacities of that body that influence our social and political behaviour (Gatens, 1996). The universal subject is the ideal human being that conforms to, and operates within, dominant discourses in society (Davies, 2005). We accord privilege to bodies that represent this norm, and the norm is always reflected in our ways of speaking and in what we speak about (Gatens, 1996). Of language, Howe (1994) writes,

Those with power can control the language of the discourse and can therefore influence how the world is to be seen and what it will mean. Language promotes some possibilities and excludes others; it constrains what we see and what we do not see. (p. 522)

The pervasive norms of dominant society could not exist without examples of deviance to

*Participant names have been changed to maintain confidentiality

measure themselves against; deviance was constructed in order for the norm to function.

Ahmed (2000) explores how we continue to recognize this deviance through Othered bodies that we define ourselves against in everyday interactions, especially those that we already recognize as “Strangers”. Kristeva (1982) argues that,

a social being is constituted through the force of expulsion. In order to become social, the self has to expunge certain elements that society deems impure...however, these expelled elements can never be fully obliterated; they haunt the edges of subject’s identity with the threat of disruption or even dissolution (p. 71).

This process of expulsion and haunting is abjection. Abjection plays a fundamental role in Othering people so that dominant norms can continue to function. Ahmed (2000) argues that, “The subject who can act and move in the world with ease – the white, masculine, heterosexual, subject – does so through expelling those other beings from this zone of the living (although the expulsion always leaves its trace)” (p. 52).

McClintock (2013) makes interesting distinctions between abject *objects* (the clitoris, domestic dirt, menstrual blood), abject *states* (bulimia, hysteria), abject *zones* (prisons, women’s shelters), socially appointed *agents* of abjection (soldiers, nurses), socially abjected *groups* (sex workers, Palestinians), *psychic* processes of abjection (fetishism, disavowal, the uncanny), and *political* processes of abjection (ethnic genocide, mass removals) (p. 72). All of these categories of abjection came to bear on the experiences of participants in this study. Participants identified fat people as being a socially abjected group. They identified particular body parts that were objects of abjection (stomachs, double chins, big arms). They described psychic processes of abjection as being disavowal, attempted weight loss, distancing themselves from other fat

people, engaging in performances of “goodness”. Participants experienced strangers, family members, partners, doctors, and therapists as being agents of abjection.

All participants discussed a sense of being “Other”, many were expelled from places where their bodies did not fit, either physically or socially. Participants received covert and overt negative messages that their body was a problem and that their body needed to be changed and/or fixed. Participants highlighted public spaces, work, clothes, family, and dating and romantic relationships as arenas where they consistently receive negative messages about their body. I will discuss each of these in turn. Participants all had experiences where they policed themselves to try and align more with dominant norms, and they described using disembodiment as a way to cope with abjection.

Public Space

My size has grown enough that entire landscapes are no longer accessible...things I didn't think about have moved to things that cause a lot of anxiety and a lot of thinking and a lot of feedback from the landscape itself and internally.

- Shira

The orientation of one's body in space, and in relation to other bodies, provides a perspective on the world (Gatens, 1999). Foucault's (1980) discussion of the principle features of power is relevant to how fat bodies are read and treated in public spaces. As discussed in Chapter Two, a negative relation is established between power and fatness and the expectation is that fat bodies are concealed or masked (Foucault, 1980). Yet concealment and masking become impossible in many public spaces. Fat bodies are then rejected and excluded. Participants discussed feeling a loss of power in public spaces. Enid stated, “In the world at large, people are still not ... forgiving if you are not ashamed of the fact that you are taking up space”. Where fatness and bodies are concerned, “power can ‘do’ nothing but say no to them” (Foucault, 1980, p. 83). The

second feature of power is the insistence of the rule. Power essentially dictates its laws to bodies. Fatness is placed by power in a binary system of what is permitted and what is forbidden. Power prescribes an “order” for fatness that operates as a form of intelligibility (Foucault, 1980, p. 83). Power is enacted by laying down the rules, maintained by language and through the act of discourse (Foucault, 1980). These rules, language, and discourses are internalized, enacted, and exercised by people, systems, structures, and societies. “By drawing attention to the context in which bodies move and recreate themselves, we also draw attention to the complex dialectic between bodies and their environments” (Gatens, 1999, p. 228). It is this orientation of one’s body in space, and in relation to other bodies, that provides a perspective on the world (Gatens, 1999). Ahmed (2000) discusses how Others are policed through understandings of who belongs in certain spaces:

...there are techniques that allow us to differentiate between those who are strangers and those who belong...Such techniques involve ways of reading the bodies of others we come to face. Strangers are not simply those who are not known...but those who are, in their very proximity, already recognized as not belonging, as being out of place. (p. 21)

Ahmed (2000) states that strange encounters serve to embody the subject. The encounters of recognizing a stranger take place “at the level of the body” (p. 38):

The sense that some-thing is wrong is communicated, not through words, or even sounds that are voiced, but through the body of another...bodily gestures express her hate, her fear, her disgust. The strange encounter is played out *on* the body, and it is played out *with* the emotions.

Mitchell (2006) discusses how space matters within discourses of power, to individual subjectivity, and to experiences of the body:

Place is generally used by geographers to identify spaces that have been given meaning through social processes. Thus, it is not space per se that establishes identity and influences subjectivity but rather the power relations and meanings that permeate space. Space, moreover, is constitutive of power relations; it is not merely a passive, abstract container in which things happen (p. 55)

The physical materiality of a city is laden with “beliefs, values and discourses of power about where bodies should be placed and what bodies need to be kept in or out of particular places” (Mitchell, 2006, p. 63). Rinaldi et al. (2020) discuss the complex affective forces that shape public interactions with fat bodies. “Unwelcome interactions with fat persons encompass concern, judgment, dread, disdain, revulsion, and violence. These expressions share in common how they operate relationally in the spaces between bodies—how they give shape to and produce in bodies orientations, directions, and movements toward and away from other bodies” (Rinaldi et al., 2020, p. 1). Participants felt the weight of discourses, beliefs, values, and reactions as they attempted to navigate public spaces. Cait stated:

It's like I don't belong...information is given to people whether physically or explicitly in spaces...it's...who belongs where...You can go wherever you want, but when you go...to sit on that spot, sit on the bus, or sit wherever and you don't fit, it's like who was that meant for?

Enid gave several examples of where fat bodies might not fit, and discussed the impact of not fitting:

I think that, in theory, you think that your size shouldn't affect anything. But some of the turnstiles, larger people don't fit through, at the TTC [Toronto Transit Commission], and that was something they didn't think about. Or some of the rides when I go to

Wonderland. I don't really fit in the seats, or I don't really fit in the safety bar and things like this. So, it affects your enjoyment of things when you go out, or it affects your ability to travel. It affects where you can live. A lot of us don't fit into doorways in buildings that haven't been retrofitted. And all of that is just really disheartening as well and...is contributing or exacerbating existing problems.

Other participants discussed the mental toll of having to navigate physical space whilst receiving messages that they did not belong. Ella stated, "I do worry about it and I do think about it and I think about squishing in...Yeah, it takes up...mental space".

"It is through emotions, or how we respond to objects and others, that surfaces or boundaries are made" (Ahmed, 2004, p. 7). As fat people fail to be the universal subject, they experience marginalization for living in a deviant body. "Many acts of oppression at the personal level reflect the notion of an inferior and/or ugly body type" (Mullaly, 2002, p. 52). Fat people suffer from being labelled insultingly. Name-calling devalues members of subordinate groups by negatively accentuating differences between the dominant and subordinate groups. It reflects the belief that characteristics of the dominant group represent the norm or universal standard and that anything not meeting the standard is open to ridicule and insult (Mullaly, 2002). Participants spoke about intrusive and negative interactions with strangers when they were out in public spaces. These interactions often involved setting a boundary around who belongs and who does not. Shira stated, "...it's hard to receive judge-y looks from people everywhere you go. Ugh". Amanda discussed getting feedback from strangers when she is out on the street, "I have had comments from strangers that are really negative and like those are kind of the worst...for someone to go out of their way to talk to you about how you look, feels just, like, so shitty". Jo also discussed street harassment, "People yell animal names out of cars at me, which is cool.

Sure, I'll be a whale. That's an awesome animal. I'll be a cow, they're cute! Have you seen cows? I don't know. People are generally revulsed by me". Ruby also had this experience, "You know, teenage boys on the street scream things. 'Pig!', 'Cow!', 'Get out of the road!' or whatever, those kinds of things".

Almost every participant highlighted public transit specifically as a space where their body did not physically fit and a space where they received hostility about their body size. Shae described a few incidents that are typical for her when taking public transit in Toronto:

I get into Bathurst Station, and I go downstairs, and someone's coming up the escalator at the same time. They just looked me up and down and went, 'Huh. You should probably lose some weight, huh?' ...Sometimes teenagers take a picture of me on the transit...I noticed someone was taking a video of me, and I literally gave them the finger.

Then...they went, 'Oh, shit.' They closed their phone...I could hear them [whispering noises], and then I could hear, 'Oh, did you see? Did you see?' ...I don't know if they posted it anywhere or whatever. I don't know if I'm becoming a meme tomorrow, but like ...You know, it's just a thing.

Jo stated, "Often, I get frowns, or on the transit, for example, people physically try to push me out of the way without acknowledging me as a person". Cait spoke about not fitting into transit seats:

I don't fit on public transit comfortably, so I think it's like more of a space thing for other people. It's like they have a right to have that, whatever it is, 17.5 inches by 14 inches seat. If you spill over onto their...I think that what gets people. People get frustrated and take that out on you.

Shae explains why she thinks people are especially hostile on public transit:

What I think it is, is that when you're on public transit, you're commuting... When you see someone breaking the rules, you're like, 'Fuck you,' and it's like being a fat person is inherently breaking the rules because you take up two seats instead of one, even if you're only taking up a sliver of that second seat and you're doing everything to fold yourself in.

Participants spoke about making seats on public transit bigger and having more single seat options as ways to mediate the hostility directed at them.

Participants also felt that the grocery store, restaurants, and food generated a lot of body scrutiny. Jo described an incident when buying a snack at the grocery store:

The other day I...grabbed a big peanut butter cup at checkout. The girl behind me was a very tall, straight-sized teenager and boy did she have a lot to say to the person she was with. 'Wow, those peanut butter cups are huge. I can't imagine eating one.' There was a whole conversation. I was like, Jesus fucking Christ. Let me just buy my fucking peanut butter cup. It's really three of the little peanut butter cups in one peanut butter cup, so I bet dollars to donuts you would've eaten the whole thing and not blinked an eye, and no one would have said anything to you. Please, let me live my life.

Nadia spoke about reactions to her eating sweet foods, and described an overt incident with ice cream and while shopping at a culturally specific grocery store:

I've been at Baskin Robbins getting an ice cream and somebody would be like, 'Do you think you need that?' And I'm like, 'Do you think you can mind your own business?'...But people feel okay to say that. And I think that's wrong...I'd be at a... specific Italian grocery store, and there are older Italian people there. And in Italian they'll comment on my body, my hair, my face, whatever. I'll 'never get a man looking

like this.’ And then I respond to them in Italian and then they're like, ‘Oh my God,’ because they don't realize that I can understand them.

Jess stated, “Restaurants. I mean you're getting not necessarily verbal feedback, but you're getting feedback about seating, and where you fit and where you don't”. Cora spoke about the work involved in trying new restaurants:

I would be really anxious around trying new restaurants, or going to different bars, because I wasn't sure what seating would be like, so I do a lot of research, and have a lot of stuff that I would worry about before going out with friends, or on an enjoyable evening. That sucks, when you have to be so hyper-vigilant about making sure you know where you're going. Then, on top of that, if you figure out, ‘This space is not going to be for me,’ let me be the person that has to tell everyone, ‘No, we can't go there.’ That sucks too.

Participants spoke about travel as being an enormous stressor for them. In my analysis of Canadian Press articles focused on ‘obesity’, travel also emerged as a significant theme.

“Discussions about fat travellers inevitably lead back to a focus on dangerously rising obesity rates, rather than a focus on accommodating larger passengers” (Abel, 2014, p. 59). Lack of space on airplanes is classified as a fat person’s problem, the implied solution to which is weight loss. Travel companies and corporations can capitalize on this individualization by charging large passengers more instead of removing barriers to travel (Abel, 2014). Cait tied this into the concept of “good citizens” and stated:

It's like thinking about who are good citizens and who can be accepted within society, and if you don't fit, let's say like in an airplane seat, then you know you aren't supposed to

be there, but then also no one cares if you can't do up a seatbelt... You're meaningless because you shouldn't have been there in the first place.

Cora describes the financial ramifications of flying while fat:

I pay extra to fly first class in a plane because plane seats tell me that I don't fit, and I'm not allowed to travel, or if I want to, I have to pay extra anyway and get two seats, so yeah, the built environment often will tell me, 'You're not welcome here. Your body's not welcome here.'

Travel is a frequent topic with Ruby and her therapist, "A lot of work we do is around travel, because I just ... It's such a stressor, bonkers, horrible thing for me. The flying". Over the last two decades, airline seats have gotten smaller, with the space between seats decreasing by about 10%. Struggling airlines are constantly working to make seats smaller and add more seats, increasing their revenue (Mouawad & White, 2013). Jo stated, "I think as we fight more and more for less and less space, fat bodies are just going to be villainized further and further, unless we fight back".

Literature shows that women are more impacted by fat discrimination than men (Baum & Ford, 2004; Davison & Birch, 2001; Drury & Louis, 2002; Robinson, Bacon, & O'Reilly, 1993; Rothblum, Brand, Miller, & Oetjen, 1990). Murray (2008) discusses that fat female bodies are discursively framed as moral failures, as diseased, and as a site of unmanaged desires. She explores the writings of Dr. James McLester, who "casts the fat woman as less-than-woman, less-than-human, unable to truly access her 'inner self'; or perhaps she does not even have a core, but is merely an assemblage of the worst indiscretions and shortcomings of woman" (Murray, 2008, p. 214). The fat female body is a source of suffering for others, it presents an

aesthetic affront to society. The harassment that participants received while moving through the world was often gendered. Jo gave an example:

I make people mad. Dudes are so mad at me all the time. The other day I was...standing in a bus stop in these overalls and my gray hair showing, in Birkenstocks. Whew, boy, did I get some sour faces from men. They were just mad at me for standing around being a fat body. Like, wow. It was like microaggression city. People were mad at me.

Ariana described an incident on a bus:

They automatically always go to fat. I got into a fight with a guy on a...bus. He was stuffing his garbage into the bellows of the expansion bus. And I was like, 'How about you don't.' And he's like, 'Fuck you. You're just a fat hooker. You're so fucking gross. No one would ever fuck you. You're so gross.'

Amanda discussed taking up space in a female presenting body:

It's wild, and it's weirdly that like often the comments are about me being in their space, like I am taking up too much space. It's been like, 'Move.' All about getting out of the way, which is I guess is something you want a female presenting body to do. Like 'You're taking up too much space. I don't like it.'

Aliya described how being racialized plays into responses to her body as well:

But it's also sometimes hard to pick apart other people's feelings about my body. Is it the fatness? Is it the Brownness? Is it the tallness? Is it the...What is it exactly? So, it is hard to pick those intersections apart because I don't just come at it one at a time. They're always there...It's complicated...

The stress of navigating public space had a financial impact on participants. Participants spent more to avoid being out in public because of the discriminatory weight-based encounters they experienced everywhere. Jo discussed using Uber:

For me, it manifests in expenses. I don't like to take the metro alone, so I often take Ubers. It's really expensive. I can't afford it expensive. My Visa is at \$11,000 dollars expensive, and a lot of that is Ubers just because it's really hard to be out in public. I realize I've been doing that for a really long time. I used to take cabs a lot. My friends would make fun of me or criticize me like, 'Walk, what are you doing? Just get on the TTC.' That was when I was hanging around with a lot of straight sized, able-bodied folks.

Ella spoke about owning a car as a means of avoidance:

I would say the main issue I have is on transportation...I like to drive. I feel like part of the reason why I don't get street harassed is because I don't go out on the street...since I don't usually take transit, it really reduces the stress.

Shira discussed being unable to save due to the stress caused by being fat in public:

I've started spending a lot of money so I don't have leave the house...I order a lot of takeout, and I take a lot of taxis...so that I minimize being in public space...I make a living wage, one would think. My fatness and class and body size intersect, because it's like I can't save any the money that I'm working very hard to earn, because to cope with mitigating public fatness as much as possible costs a lot of money. Privacy costs a lot of money. A good pair of headphones costs a lot of money. Buying your seat and the seat next to you on the plane or the bus or the train costs a lot of money. But there are a lot of lengths that I go to...Because spending the money is worth not having to be fat publicly.

Work

Studies focusing on fatness and employment issues have found that fat people are significantly disadvantaged in the workplace (Baum & Ford, 2004; Larkin & Pines, 1979; Rothblum, Brand, Miller & Oetjen, 1990). Larkin & Pines (1979) found that employers see “overweight persons” as much less desirable employees. Fat employees were seen as less competent, less productive, not industrious, disorganized, indecisive, inactive, and less successful (Larkin & Pines, 1979). In a simulated work setting, these stereotypes resulted in equally qualified bigger applicants being significantly less likely to be recommended for hiring (Larkin & Pines, 1979). Even if a fat person is hired, they are more likely to experience types of employment discrimination such as being denied promotions or raises, demoted, fired or pressured to resign, being questioned about their weight or urged to lose weight (Rothblum, Brand, Miller & Oetjen, 1990).

These studies illustrate why fat people often have a lower socioeconomic status than thin people (Ernsberger, 2009). Weight discrimination and stigma can result in unemployment or low-paying work. Fat and thin people score equally on intelligence tests, but intelligent fat people are far more likely to end up living in poverty than intelligent thin people, because of the multiple employment barriers (Ernsberger, 2009). Participants echoed the existing literature when expressing the ways that fatphobia manifested in their professional lives. Shae felt that she wasn't finding work due to her body size, “I feel like I am being discounted from consideration at all, for a lot of the jobs I'm going for. It's like they're not even double-checking because it's like, ‘Well, she must be lazy...She's fat!’”. Shae also felt that she was less likely to get hired for the kind of job she is good at:

No one wants to hire a fat person for a job that's considered high energy or a lot of recreation, but I have to carry this body around day after day. I can lift 50 pounds. I can

carry a box. That's usually what the physical requirement is for a lot of these event coordinator jobs, which I'm really good at. I'm really good at connecting people and doing all that stuff. But...I feel like I'm not even being considered.

Cait experienced a similar bias in an interview:

I was in an interview and I had asked what the ideal candidate within this job would be and the boss was like, 'Oh, someone who's nimble and can move and can like keep up with a fast pace' and whatever. I was like, 'So not a fat person.' It was in those moments where I was like, 'What the fuck? Really?'...I don't think like nimble is really a word to place within a job interview or that that's an ideal qualification. That's like, what your ideal person is going to be like? When I think of nimble, I think of little, small little mice. I'm like, 'Okay, I'm not that.' It was very apparent without saying it explicitly.

When fat employees do get hired, they consistently earn less than their thin peers (Baum & Ford, 2004). On average, fat women make \$6710 less in a year than thin women (Solovay, 2000). Cait described a time where she was paid less:

I've been paid less for some jobs based on the way that I look. Maybe not explicitly, but in comparison to other people. Or being passed over for jobs because of it...There was one job where...the hiring manager or supervisor person was an active runner and I am not an active runner and probably have no intentions of being an active runner. The person who was my peer was also an active runner and would talk to her about running. It came out that she made \$2.50 more than me an hour, but we were doing the same job. In those instances, I was like, 'I'm just as qualified of you. I have all the same qualifications. I have more experience.'...She was like, 'Oh, I don't know why, I don't understand why.' I was like...I can probably give you some suggestions as to why.

Several participants described their workspaces as inaccessible for fat people. Participants also felt like they couldn't raise these issues. Cait described the chairs at her current job:

I've been working there for three years and I still don't feel comfortable enough to be like, 'I need a chair without arms.'...I really should because I can't get up onto a chair that is elevated. And then if I break it, I would be absolutely terrified, but I just stand...or I find a different stool.

Even though Cait was struggling at work, especially as they began to discontinue the stools she was using in favour of chairs with arms, she didn't feel comfortable advocating for herself:

It shouldn't necessarily always be the worker or the student or the person advocating. There should be at least avenues that allow for those discussions...I don't think I could go to my boss and be like, 'So I worked here for three years and just FYI, the chair has been extremely uncomfortable for the last three years and I've had enough.'

Ruby has also struggled with chairs, but as she is senior in her company she felt able to advocate when necessary:

I mean, I've been here for so many years in this office and like I've got a lot of privilege. I can just say, 'What the fuck, Brenda, why did you order these fucking chairs that don't fit? That I can't fit in to? Can you please make sure there's boardroom chairs that I actually can fit in to or find a way to move those arms?' And she'll be like, 'Oh my God, okay. Sorry.'...I don't think I could have ever said that when I was younger.

Aliya chose to resist at work by repeatedly using the phrase "I'm too fat for this.":

It's usually if I'm at work, and there's something like ... There's a teeny tiny thing, and I still have to get through it. I'm just like, 'I'm too fucking fat for this. What the hell?'...I'm criticizing the smallness of the space that I'm being forced to go into, but people are kind

of like, 'I don't know what to say about that.' It's sort of like 'I'm too busy for this,' but sort of like 'I'm just too fat for this. This is not happening. You can move this through here,' or whatever.

Navigating a workplace culture where weight loss discussions are rampant was difficult for participants. Jess stated, "It makes me distance myself from them. It makes me uncomfortable. I don't love the job as much as I could...I guess I just use my existence almost as a retaliation...I don't know. It's a small very...very close-quarters group...It is incredibly awkward". Jess was distressed about an incident that had happened before our interview:

It came up today about this woman that I don't work with directly...But apparently...she lost 100 pounds since January or something, because she had...weight loss surgery. I'd never known her before, but everyone was talking about how great that was. I'm like, 'Okay, well I wouldn't say that that's great. That is very dramatic.' And then relating it to her worth. Yeah. Those messages suck. You just have to power through it...

Participants suggested things like having a suggestion box, having accessibility presentations at work that included body size, and doing ergonomic and accessibility audits for all employees as ways to approach the struggles that fat people face in their workplaces.

Clothes

I just don't like the term plus-size because...it is creating this default of what it is to be normal.

- Ariana

Clothes play an essential role in how we come to know ourselves through our bodies. Clothes are objects used in the performance of subjectivity. Hebdige (1991) has written extensively about the role of designed fashion objects in the articulation of cultural practices. His work argues that

clothing is a necessary cultural resource used in identity work. The connection between self, body, and clothing is indivisible. “The body constitutes the environment of the self, to be inseparable from the self” (Entwistle, 2015, p. 273). As such, clothing becomes an “extension of the body and acts as a second skin in establishing the physical boundaries of the self” (Horn & Gurel, 1981, p. 138). To be denied access to fashion is to be denied voice.

Young (2005) states that fashion offers women “a double dream of identity and play—indeed, the invitation to play with identities” (p. 10). However, bodies that exist outside the normalized representation of society’s cultural beauty ideal are regularly denied access to the requisite cultural materials needed for this fundamental identity work (Rudd & Lennon, 1994). Susan Watkins has identified clothing as a “portable environment,” as “it is carried everywhere with an individual, creating its own room within a room and its own climate within the larger climate of our surroundings” (Watkins, 1995, p. xv). Thus, clothing creates an external environment closest to the self. As such, clothing becomes an “extension of the body and acts as a second skin in establishing the physical boundaries of the self” (Horn & Gurel, 1981, p. 138). The lack of options and availability in plus-size clothing limits the potential for fat consumers to feel good about their “portable environment”, can cause them to feel “alienated” from smaller sized people, and defensive about their own larger bodies (Downing Peters, 2014, p. 59). All body shapes and sizes should be able to access clothing that fits well and allows them to express their individuality.

Participants expressed that the lack of access to clothing has a variety of impacts on their lives. They expressed frustration about not being able to fit into clothes that felt like their style. Shae stated, “I look back to at like all my tomboy stages of life...and I think about how much of that tomboyishness was actually chosen and how much of it was ‘these are the clothes I can have

access to”’. Many participants began by looking back on their childhood and described the difficulties of not fitting into children’s clothing. Shae brought the following photo to her interview, and discussed what she was wearing:



Figure 5. Summer Look

I'm wearing my summer look...I wore board shorts and a Spider Man T-shirt, and I had three of each. I had three pairs of those board shorts, a gray, a blue, and like a gray blue. And the shirts, I had a red one, a black one, and a gray blue...I remember them so clearly because that was the summer that I couldn't buy cute summer clothes for the first time, because I had officially grown out of any sizing available in my town. We didn't even have Old Navy yet, so there was literally nothing. This whole outfit is from the husky collection at a Zellers. It's what I wore all summer long because I was too fat. The

summer before this, I was swimming every day. I was biking to the beach...I was really, really active that summer, but then this summer, because I didn't have any of the clothes I needed, I basically stopped biking and swimming and doing all that stuff. It kind of strikes me as so sad, because I look at this girl...and I'm like...if a Torrid had existed, if an Old Navy had existed, if anything had existed for me at that time, would I have kept up with those activities I really enjoyed the most?

Jo also recalled the ongoing struggle during their childhood and teenage years to find clothing that fit:

My mom was so embarrassed of me. Most of the time she couldn't find clothes that would fit me, so I was just this huge unmanageable person she didn't know what to do with and she couldn't clothe...In Canada, a lot of straight sized lines in the '90s only went to a size 12. I fatted out of those...My mom...had to drive me to Buffalo to go shopping. Addition Elle was dire at the time...It was just a struggle all the time...

Young (2005) discusses that clothes for women are often “threads in the bonds of sisterhood” (p. 8). “Women often establish rapport with one another by remarking on their clothes, and doing so often introduces a touch of intimacy or lightness into serious or impersonal situations” (Young, 2005, p. 8). Young also describes that relations of intimacy are often established by sharing or exchanging clothes. “As the clothes flow among us, so do our identities; we do not keep hold of ourselves, but share...In relating to other women though our clothes we do not just exchange; we let or do not let each other into our lives” (p. 8). “Women often bond with each other by shopping for clothes...Women take care of one another in the dressing room, often knowing...when to encourage a risky choice or an added expense” (Young, 2005, p. 9). Participants spoke about being barred from these experiences of bonding and

intimacy due to their size. Amanda described a situation where she took a friend shopping and simultaneously realized that she no longer fit into things:

I like clothing. I like fashion, and it's still a point of frustration...I was shopping with a friend so she could go to a wedding, and it was like let's go to the mall, like let's go shopping...And every store...we go into, I think it was the first time I had the realization that I couldn't shop anymore. So, it was just like, 'Oh, shit.' Like nothing...My friend...was like, 'I need someone to go with me. I need some help.' But I was also then having my own like, 'Oh fuck, I can't shop any of these places.' I know where I can take you, but I can't enjoy this. I can't really have a girl's day out thing, because I just can't.

Jo also highlighted shopping as a place of tension with their smaller friends:

I'm tired of being friends with folks where I'm expected to be the sidekick and the therapist...It's fucking tiring...We can all be co-stars, and all have our amazing best lives together and support each other through shit, but holy fuck, am I tired of helping you process all of your feels and being dragged to stores where I can't shop too.

Several participants described experiencing strange or uncomfortable interactions when they were shopping. Getting ignored by salespeople was a common theme. Nadia explained:

Oh yeah. So when I go to the mall and I go into a store...I notice that I don't get approached by people who work there as much, which I think is fascinating...I don't know if it's intentional or not, so it's just my observation, but it seems to happen a lot.

Ariana shops online to avoid interactions with salespeople:

I do a lot of my shopping online, try everything at home and then go return in store because I find going to fitting rooms can just ... It can be a lot for so many reasons...I get a lot of looks. I also find that the person taking my clothes to hang them up...will take the

clothes from me, look at the clothes and then size up my body like, 'Does this bitch really think she can pull this off?'... 'This colour is not going to go with your weight.'

Participants also spoke about the few plus-size options that now exist, and how salespeople working in those stores behave. Aliya described her interactions:

I feel like, when I go to plus-size stores, I get a lot more weird feedback from the people working there as they're trying to... Okay, I'm namedropping Addition Elle and Penningtons and stuff. Their training is so weird. I dated someone who worked at Penningtons... We had a lot of talks about what their fat politics are like there. It's a place where fat people go, and they have a very specific way of talking about it. It's very much like, 'Oh, you're not fat.' It isn't from the fat positivity that I'm looking at... Like, at Torrid, they've changed their sizes to 0, 1, 2, 3, 4, 5, so you can have a little fucking five on your clothes because you've never had a five on your clothes. That doesn't do anything for me. Does it fit me, and is it not \$100? Great. I don't care if it says what my actual size is, because that helps me to find it. I don't want to have ask you 'What is a 6?', 'Oh, that's a 7X.' They don't even correlate.

Participants highlighted the importance of customizable clothing from companies such as eShakti as a way for them to navigate not being able to find clothing that fits, sizing being inconsistent, and having unpleasant interactions with salespeople.

Family

Mothers are very powerful things. Parents. Immediate families are very powerful things, and they can have a very intense influence over our relationships to ourselves.

- Shira

“Family exists as a space wherein we are socialized from birth to accept and support forms of oppression” (hooks, 1984, p. 36). Foote & Franke (1999) discuss how technologies of the self allow people to enact operations on their bodies to transform themselves and attain happiness or purity. Heyes (2006) has theorized that dieting and attempted weight loss are enacting technologies of the self. The construction of a “normal” and “desirable” body weight supports the control and monitoring of human actors and contributes to the discrimination and marginalization that transgressive bodies face (Hansen, Berente, & Lyytinen, 2009). Foote & Frank (1999) state that although such technologies depend on the individual acting on themselves, they do not act alone. “Technologies of the self...always are played out in relationships”. (Foote & Frank, 1999, p. 162). Discipline of the body is often played out through familial relationships.

Davison and Birch (2001) found that parents often restricted their children’s food access, and directly or indirectly criticized them about their weight. Bordo (1993) discusses the cultural and identity work done in the family as “not simply contributory but productive of eating disorders” (p. 40). Solovay (2000) states that fat kids and teens experience repeated physical, verbal, and emotional abuse because of their weight. This abuse often comes from their own family. “Home spaces do not provide the kind of safety or freedom from surveillance that one might expect” (Mitchell, 2006, p. 171). Mitchell (2006) discusses the parental home as the place people first come to know themselves as fat, via familial relationships. “The parental home as experienced through their bodies carries on long after that place has been left” (Mitchell, 2006, p. 173).

Participants all discussed the significant impact that their family had on their understanding of their body from childhood to present. Participants discussed their mothers and

fathers most, but also discussed hurtful feedback from siblings, grandparents, and extended family members.

Mothers

All participants spoke about the complex and often fraught relationship their mothers had with their body (and often her own body) as they were growing up. Shira stated:

When my opinions about myself and my sense of humanity were being formed in adolescence, my mom made it very clear that she found me disgusting, that she found my body disgusting. That is a seed that was planted and that took very strong roots. So, grade 7, 8, 9, 10, my mother was making me diet, and I was watching my weight extremely closely...My whole life up until 18-19, I was really concerned with the number on the scale and all of my lovability, worthiness, worth, capability ... Any good qualities about me were intimately tied to the number on the scale.

Jo discussed the impact of forced migration and desired assimilation on their mother's relationship with their body:

My mom was really embarrassed by me. I didn't conform. My mom's side of the family are Holocaust survivors. They got on the last train out of Chelm, Poland before the Nazis got to the town...They came over to Canada in 1952. Then they were very, very poor...More than anything, my mom...wanted desperately so much for me to be this perfect, skinny, white Canadian daughter because being a Jew in '50s Montreal was really fucking hard...Anyway, yeah, ashamed of me. My mom was mostly ashamed of me.

Ella was impacted by her mother's relationship with her own body:

My mom was extremely critical of her own body. My mom is still constantly on a diet and she's not fat...she always felt like she wasn't small enough...She was always eating

ice or just eating Ryvita crackers with onions on them, which ... Nightmare. She had thinspo up in our kitchen. It was bikini pictures from catalogues...when I became heavier...I was really worried about it and I expressed my concerns to mom and she was, 'Oh, it's okay, you can go on a diet.' That was the reaction, not acceptance, but dieting.

Diane reflected on her mother's reaction to her body in the context of parenting her own children:

One of my kids is 10 and it struck me the other week I was like, right, when I was 10 my mom took me to Weight Watchers, like signed me full on up to Weight Watchers. I can not imagine doing that to my kid who's 10. She's a tiny little human, you know?

After Diane found literature about fatness and began to develop a new understanding about bodies, she tried to explain this to her mother, "I remember having this horrible conversation with my mom about fat politics once. This was when I was 20 or whatever. My mom would just be like 'I don't know what the fuck you're talking about.' It was a really bad conversation".

Fathers

Fathers also participated in behaviours that negatively impacted how participants felt about their bodies. Shira's father reinforced the shaming her mother was doing:

My father was quite fat when I was young...he had struggled and really felt tied to the number on the scale...So, there was a lot of influence from him about...My mother would shame both of us, and it was almost like my dad was like, 'She's right though. We should be shamed if we're being fat, if our numbers go to a certain number,' or 'Why aren't you losing more weight?', or 'Why aren't you losing weight fast enough?'

Jess stated, “My dad's side of his family had...people who were...fat. He ... it was almost, saw their experiences and saw their difficulties that they experienced, and would therefore put...more pressure on me”.

Amanda’s father would focus on how much she was eating:

My dad would make very weird comments like, ‘Oh my god, you're eating like a huge plate of waffles.’ I was like, ‘I'm eating two Eggos,’ which is a pretty normal serving of Eggos. But like I can still remember that comment and I must have been like 10. So that's bizarre. But you just, you hold onto those comments.

Ariana’s father had specific expectations for his children’s bodies that he did not have for others:

My father was a really big cause for a lot of dysphoria and hatred towards my body...But the funny thing is that my paternal grandmother is a fat woman, and she's not just large. She is a fat woman with large saggy breasts...My dad would call her ‘Fats’, and it was a term of endearment, and that was totally fine, but his children were not allowed to be fat.

Ariana felt that being mixed-race contributed to the differing standards:

We have this underlying sentiment that my father loves us...but there's a strong part of him that hates that we're mixed and hates that he's with a White woman...I think that's where a lot of that damnation for being fat comes from...‘You have to be Blacker. You have to be better,’ and he was always comparing us to all of the other kids.

Other Family Members

Other family members also felt free to comment on participants’ bodies. Cora was influenced by how her extended family viewed their own bodies:

My family's pretty body-focused, not so much my parents, but our extended family.

Nobody's saying to me, ‘This is what's wrong with your body,’ but the way they talk

about their own bodies, and their own food restrictions they put on themselves, that tells me what I need to know about how they view fatness.

Jo's family had a lot to say about their body, "My extended family? Oh, boy. They were always telling me diet advice, or telling me to stop eating, or asking me if I wanted to put that in my mouth". Jo was close with their grandmother, who also took the opportunity to solidify norms:

My Bubbie, when I was three and a half or four, she came for a visit. I have this memory of sitting in the back of the car with her. She said, 'Do you want this candy?' Because she used to carry around candies in her purse. I said, 'Yeah, of course.' She was like, 'You have to promise that...you're going to take care of yourself. You have to make sure that you take care of your body.'

Jo described another incident that took place with their grandmother when they were a teenager:

When I was 15, she said to me one day, 'I'm worried about you.' I was like, 'What?' She's like, 'Yeah, I'm worried you're not going to find a husband because you're too fat.' I was really wrestling with my sexuality; I was so deep in the closet at that time. Holy shit. Mainly out of self preservation, but I was, do I want a dude? What do I want? I don't know. Maybe I should go on another diet...

Aliya described the feedback she gets from her extended family:

Kind of a lot of 'ifs' of 'If you ...', 'You could lose some weight ...', 'If you just lost a little bit or if you just tried a little ...', 'Focus and try really hard, you could definitely be pretty ...' Or, I don't know. Some bullshit like that. I don't think I'm really aiming for pretty at this point, but it's also interesting what people think that you aim for on your looks is versus where they perceive you to be actually at. You're like, 'That wasn't even what I was fucking going for, so you can just be quiet. That would be cool.'

Nisha discussed how body shaming from her extended family in India feels much more overt than it does in Canada.

When I go back to India, I'm constantly reminded about how big I am. Maybe if I lost weight I'd be more attractive, maybe I'd snag a dude. I don't know. The whole gamut...My family is obsessed with thinness at any cost. It's very overt, it's okay to tell people,...'Your skin is too dark,' or 'You're really fat,' to their face, and you've just met them...You're supposed to be like, 'I know, I'm trying to lose weight.' That's the appropriate response...It's like it is the worst possible thing you could be, as a South Asian woman.

Sunil described being unable to remove the intersections from how his family responds to his body:

A few of my cousins...So there's this term in Hindi, but roughly translated in English, it's ... someone called me black dot ... The black dot is basically for shame and colour, both. And then, I would have people commenting constantly about my weight because my siblings were very lean.

Sunil also highlighted the intergenerational experience of body shaming, how beauty ideals were passed on from one generation to the next:

My father had 7-8 siblings...His mother used to call him black and he was not given enough love by his mom because he was kind of a darker-looking kid. Can you imagine? ...Apparently my mom was called too fat by her mom...They've carried that tradition into us too. And a matter of fact, my sister also does that to her kids. She rations things to a very unhealthy point. The kids, they have not had junk food in years. I mean, it's a kid. Give them a slice of pizza.

Participants described pushing back against family, with mixed results. Many no longer pushed back because they felt it was a waste of time and energy. Others had some success with stopping body talk, but still felt the judgments. Aliya stated, “I’ve fought my family so hard on this for so long that they’re not really making as many comments anymore, because they’re just like, ‘She’s just going to tell me off,’ which took a long time to get to ... But it still comes out, you know?”.

Dating and Relationships

Fat bodies are consistently and repeatedly punished for contradicting the thin beauty ideals that are privileged, and this often becomes particularly relevant during romantic and sexual encounters (LeBesco, 2004). Participants’ sexuality, dating history, and partnerships came up frequently during the interviews. Participants received extensive feedback about their size when dating and while in relationships. Several participants experienced size-based abuse and violence within their relationships.

Murray (2004) explores the silence around fatness and sexuality, “We do not talk about fat and sex. The two appear as mutually exclusive...we do not fantasize about the fleshy jiggles and wobbles of a fat body in the throes of sexual passion. Some of us might. But most of us do not. Or at least we know we are not supposed to” (p. 239). Fat women in particular are viewed as deviant, lazy, out of control, and nonsexual (Gailey & Prohaska, 2006). A societal emphasis on bodily flaws works to keep women in general, and marginalized women in particular in a place that is passive, submissive, and other-oriented (Gailey, 2012). “The fat woman...does not fulfil feminine expectations of beauty and submission: she takes up too much space, she is uncontained and excessive” (Murray, 2004, p. 243).

“In the mainstream sexual marketplace, fat bodies are not marketable commodities” (Murray, 2004, p. 239). Gailey (2012) interviewed 36 fat-identified women about their sexuality,

and 94% of respondents indicated that their relationships and sex lives suffer because of the ridicule and body shame they experience. Fat women identified the challenges of trying to form relationships when negotiating fears that men might reject them, ridicule them, or use them. 19% of participants reported not feeling comfortable removing their clothing in front of another person because they did not feel sexually desirable (Gailey, 2012).

There are contradictory images of fat persons as either asexual or hypersexual (Owen, 2007). On the one hand, fat women are most often relegated to the asexual category of the “big girl” (Murray, 2004). Fat women are often not permitted to experience sexual desire at all, let alone sexual pleasure (Murray, 2004). Fat women frequently deal with the discourse of having a “great personality”. Having a “great personality” is often code for being ugly, undesirable, and non-sexual (Fierce, 2011). For a fat woman to be considered a sexual being or an acceptable romantic partner, fatness is something a person has to overcome, something they have to lose (Fierce, 2011; LeBesco, 2004).

Opposing the asexual fat woman is the stereotype of the desperate hypersexual fat woman. Owen (2008) makes an interesting connection between loose bodies and loose morals. Fat women are seen as willing to do anything for anyone who is kind enough to actually engage with them sexually (Owen, 2008). Jess spoke about navigating the idea that fat women are willing to accept more bad behaviour from the people who they are dating:

You're willing to accept more, and shove more under the rug. You're willing to tolerate more, because you're not as accepted...there's a lot of men who want to have sex with fat women, but don't want to date them. I think it's more that you're willing to just tolerate people's crap more. They just think that they can...take more advantage, I think.

Cora spoke about being objectified in BBW spaces and feeling like her agency is taken away:

In BBW spaces, I receive a lot of attention for my body, and I think the people giving it think it's coming from a good, like it's good, like 'Oh, I'm attracted to you. You should be happy with this,' and it just makes me feel the more it happens, the more disconnected I feel for myself, because I start to feel like I'm just this thing on display... I'm not creating that displayness. They're...imposing it on me.

Ariana discussed how race and fatness intersect in her experiences on dating sites:

The types of messages I get...I get 'fat slut' and 'fat bitch,' or the n-word because of course we have to sprinkle that in there every so often...Most men are just so upset that they can't find anyone. And then when they're scraping the bottom of the barrel, in their opinion, by messaging me, and then I further reject them...however I choose to go about it, they're always just so incredibly insulted that a Black woman has turned them down, and a fat woman has turned them down. How the fuck dare I?

People are often unwilling to admit to their attraction to fat folks. In a study conducted by Gailey & Prohaska (2006) men indicated that if they had been with a fat woman that they would try and keep it a secret. Fat men also did not want to be with fat women because other men would make fun of them and undermine their masculinity (Gailey & Prohaska, 2006). Women have become currency that men use to improve their ranking on the masculine social scale (Kimmel, 2007). Fat women often experience the humiliating and negative experience of being with a partner who is embarrassed to be seen with them (Gailey, 2012). Shae discussed how these harmful ideas and behaviours impact her marriage:

Sometimes the reason I blow up at my husband is because we haven't gone on enough dates and I tied that idea of going on a date to being seen in public with him. And if he doesn't want to be seen in public with me, then he's not attracted to me...It's just...spend

time with me outside. That's all I want. I don't want to be an inside wife. I get really emotional about it, but he's just a homebody and it has nothing to do with him being embarrassed of me...my weight...it's clearly a factor in my most important relationship.

Jo tied together the impact of the dominant narratives that fat bodies are not attractive and that fat people will accept bad behaviour from anyone who is interested in them:

I also feel like in the wider context of patriarchy and the world, people aren't allowed to be attracted to fat bodies...BBW porn is the most popular porn. I think people are actually really attracted to fat bodies. Because we live in a society that denies that attraction, it fucks with people a lot. When they see someone who is attractive to them who they've only really accessed ever in porn, maybe that all of a sudden there's that person and they just feel like they're able to touch them, they have that permission.

Because fat people are not supposed to be sexy or sexual, “any sex involving a fat person is by definition ‘queer,’ no matter what the genders of any partners involved” (Hill, 2009, p. 5). All but one of my interview participants identified as queer. Queer fat people bring the language and identity politics of their communities into fat activism, and several of the fat acceptance movement’s most prominent activists are queer, bisexual, or lesbian-identified women (Hill, 2009). Queer fat activists demand that fat bodies be recognized as beautiful and sexually desirable, not just that fat women be loved in spite of their body (Hill, 2009). However, in the queer community, as anywhere, fatness can be controversial and despised (Blank, 2011). Enid discussed the struggles of squaring their body size with their sexuality:

...the queer community in general is a little harsh to bigger people. I also present largely as femme, which means that I don't really fit into the sort of...The set group of women in

the queer community...dykes or bull dykes, are generally assumed to be the larger people.

Ariana also discussed how body size impacted her assumed role within the queer community:

I am a larger woman, but I'm not butch and I'm not a butch dyke and I don't take on that appearance, and I ... It's just not me...I'm much more femme, and I enjoy being femme...and they're like, 'You're not allowed to be a fat femme. Those aren't real. You're not allowed. If you're fat and you're queer, you have to be a butch dyke,'...I'm too fat to be a woman who's into women if I won't assume a particular role. It's not cool.

Nadia discussed how stereotypes about fatness being sexually undesirable impacted her as she was coming to terms with her queerness:

Once I came out, I remember...one of my friends saying to me, 'Are you a lesbian because you can't get a boyfriend?' And I was like, 'Um...'. Part of me was like, what do you mean I can't get a boyfriend? All I did was have sex with boys in high school, what are you talking about? Then, the remark that followed that was, 'Well, we're not in high school anymore. The rules are different,'...And I was like, 'So, are you implying that I'm not attractive enough to meet somebody on my own and go ahead and do whatever I want to do?'

Sunil discussed how racism and body stigma are prevalent in the gay community:

I lived in a country where homophobia is so bad that it's incriminating just to be a homosexual person. You can be in prison for life if you have homosexual sex...So my intent to move to Canada...was because this is touted to be the most queer-friendly country in the world. What people didn't tell me is, sure, it's the most queer-friendly country in the whole fucking world, but it's also the most subliminally racist country in

the whole universe...if you're a queer person of colour, you are fucked like nobody's business...White boys don't want to date me and I'm not Brown enough for Brown boys. Some days, I'm not queer enough. Some days, I'm not top enough, I'm not bottom enough, which is another thing that they have. And then, there is twinks and twunks, and jocks, which are even more fucking skewed perceptions of masculinity and body image issues. Do you know in queer culture, these sub-genres are actually body types. They are not queer characteristics, mind you...Are you fucking kidding me?

The negative stereotypes surrounding fatness and the framing of fat people as undesirable partners who should be grateful for any attention at all, permeated abusive relationships that participants had been in. Ariana describes her experience after gaining weight due to starting a new medication:

The boyfriend at the time, rather than being there for me...he became distant, and he actually started using my weight against me and saying things like, 'No one's ever going to love you because you're too fat,'...he stopped giving me oral sex...He's like, 'Well, I still want you to go down on me, but understand that you're fat, so it's gross now. I don't want to look at you like that. It's not a pretty view. You're too fat.'...He cheated on me. He would try to leave me, and then come knocking on my door and be like... 'Fat girls do it better, and they're grateful, and you should be grateful that I'm paying you attention.' That fuckery went on for 5.5 years because he had completely destroyed any semblance of self-esteem that I had...I finally got rid of him, just finally fucking got rid of him. Fucking asshole had to have his last laugh and raped me after we broke up.

Ariana felt that the sexual violence happened because her boyfriend couldn't tolerate being rejected by a fat, Black woman who was finally taking a stand against his abusive behaviours.

Raping her was a way to regain his power and put her in her place.

Sunil spoke about a physically and emotionally abusive ex who insulted his body as a way to put him in his place:

So, my ex, he would hold me in front of a mirror, stand behind me, and hold me. He used to tell me to say it out loud looking at myself in the mirror and say that, 'Tell yourself you're not good enough for me. I'm too good for you,' every single day. I think that broke me. It chipped off my soul, every fucking day.

Many participants spoke about accepting their fatness and finding fat positive resources as a turning point that allowed them to demand better on dates and in relationships. Gailey (2012) studied the impact that involvement in fat acceptance movements had on the participants' body image, relationships and sexuality. 72% indicated they have less body shame since they became involved in fat acceptance activism (Gailey, 2012). This confidence also empowered many women to get out of disrespectful and abusive relationships that they were maintaining because they feared not finding anyone else who found them attractive. 72% reported positive sexual experiences and relationships after discovering the fat acceptance movement and beginning to take pride in their bodies (Gailey, 2012). "To embody a fat identity is subversive and a form of political resistance. Acts of subversion and resistance to dominant social forces can be empowering" (Gailey, 2012, p. 122). As people experience less body shame and more confidence they feel a new freedom to be sexual, and they seek out partners who treat them better.

Policing the Self

Butler (2011) discusses gender as an “assignment which is never quite carried out according to expectation, whose addressee never quite inhabits the ideal s/he is compelled to approximate. Moreover, this embodying is a repeated process” (p. 231). Embodying an appropriate body is also an ongoing and repeated assignment. Participants spoke often about continuously trying to contain themselves, to be more acceptable, as if this were an assignment that they were always trying to complete. Participants struggled with being considered ‘non-people’, always being looked at “through a lens that only focuses on their limitations” (Brisenden, 1998, p. 23). Wendell (1996) states, “For many of us, our proximity to the standards of normality is an important aspect of our identity and our sense of social acceptability, an aspect of our self-respect” (p. 88). “The fat body exists as a deviant, perverse form of embodiment and, in order to be accorded personhood, is expected to engage in a continual process of transformation, of becoming and, indeed, *unbecoming*” (Murray, 2005, p. 155). Murray (2005) discusses that fat women try to avoid the negative responses that their fat body elicits. “In adjusting their behaviors, fat women believe that they can overturn the ‘social knowingness’ that exists about the appearance and practices of the fat body” (p. 274). Participants discussed their bodies as compromising their ability to perform respectability and acceptability. They described policing themselves and feeling pressure to present a certain way to compensate for already failing to meet normative body standards.

Enid discussed clothing as a factor in the performance of personhood:

Up until a couple of years ago, I was very careful about what I was wearing, and I was very careful about how I presented myself to the world. I still am, because I feel like fat people sort of get rolled into that...minority role where one fat person is representing all

of the fat community. So, I think we have to try very hard to look good and presentable at all times, because if a fat lady wants to wear a pair of sweatpants, she's let herself go.

Ariana discussed how being racialized and fat leads to increased self-policing:

I ... being Black, I constantly have to do the minority check, which is count to see how many non-White people are in here to make sure I didn't walk into the wrong room...I have to constantly pat my dress to make sure that I'm not hanging out, that I don't look gross, that there's no food on my face because I'm around a bunch of skinny people, because they're looking for that excuse to say, 'See? All fat people are gross!'

Shae discussed becoming a caricature in order to make others feel more comfortable:

I ended up creating this desperate need to be fun and bubbly all the time, almost like an armour. Because it was like, 'Sure, I'm fat, but look at me. I'm so fun! You want me around. I'm so caring, and I'm so sweet, and I'm so this...'...how much am I being myself, and how much am I being a performance of a fat person in order to gain acceptance?

As participants worked to stop policing themselves and set boundaries around what was acceptable to them, they saw consequences in their social lives. Shae discussed this around eating:

Again, it was about this performative stuff around like, 'Well, if I go out to eat with certain groups of friends, I'm expected to eat the most so that they all feel more comfortable eating'. The more I started putting boundaries on that, the more I started noticing certain people didn't invite me out to dinner anymore.

Nisha lost a friend because she was confident and socially and professionally connected:

What happened was we threw a joint birthday party together. Only one of her friends showed up, and 35 of my friends showed up. Literally, the next day, she ghosted me...I feel like, in that context, my non-threatening fat girlfriend thing, maybe she had thought of me as her duff [dumb ugly fat friend]...Maybe that night it hit her that I'm not her duff.

Nadia's marriage broke down:

I was with my ex-wife for 18 years...when I started to become more confident about my body, she moved further away from me, and I couldn't figure that out...I think the confidence that she was seeing emerge ... I don't know if it scared her or she didn't know what to do with it...but it just made things not better between us. It was the weirdest thing. I couldn't figure it out.

Many participants spoke about worrying about and monitoring signs of physical exertion to avoid judgement. Shae stated:

I don't want fat people to get a bad name, based on my behavior. Right? If I'm out of breath when I get to the top of the stairs, it's almost like every fat person would be out of breath when...It reaffirms confirmation bias, and I don't want that for people in my affinity group.

Shae discussed preparing for therapy:

The only way to get to his office is a pretty deep flight of stairs, so I do give myself extra time, which I should do for every appointment, but specifically for him so that I can go to the bathroom, even if I don't have to go to the bathroom, just so that I can catch my breath so that when I walk into his office, it's not like I'm out of breath from his flight of stairs...Whose comfort am I doing that for, really? You know? I know it's personally for

me, because I'm like, 'One flight of stairs and I'm winded. This is embarrassing.'

But...they're a weird set of stairs.

Cora recently moved back in with her parents, and spoke about how body shame manifests in shared living space:

It's been interesting living at home, because for nine years I was alone, so I didn't have anybody in my space, witnessing what it's like to live as a fat person. Now, I just feel like I'm always on display. If they see me, I don't know, climbing the stairs, and I can't do it as fast as I used to do it...I wonder what are they thinking...Then worrying, if they hear me being out of breath once I get to the top of the staircase, what are they thinking, stuff like that. I'm a little bit self-conscious at this point.

Ella discussed altercations during and after the aquafit class she attends weekly:

...she made a comment that I was sweaty, which wasn't true, which was wild because I'm self-conscious about how sweaty I am...but I actually wasn't sweaty this time. I was wet from having just been in a pool. I was wearing a purple t-shirt, so when I put it on I wasn't totally dry. My hair was still dripping and it got wet on the back.

Diane discussed going to a fat dance class in a regular dance studio:

We'll be doing our thing and then the next dance class will be there and it's like all of these typical dancer bodies sitting there just watching. Not being, you know, there's nothing about them that communicates to me that they're laughing at us or judging us...just the fact that they're regular dance bodies and the fact that, you know, dance is so incredibly gross and fatphobic around bodies...We're fat and we're dancing and that's fun. Out there it's like we're being surveilled by these dancers, which feels weird.

Whether others were judging or confronting or not, participants continued to police themselves, be on guard, and modify behaviours because they feared having a negative encounter. Cora spoke about her parents, “They've never made me feel attacked or uncomfortable with my body. It's like my own projections onto them that give me a sense of discomfort every now and then”. Aliya discussed projecting as well, “I spend so much time...overthinking what other people think of my body, and I'm just like, ‘Damn, this is tiring. I'm tired’”. Cora stated:

The more I think about what actually happens to me, versus what I think might, or what I'm projecting, the more I feel the projecting is what's happening, because I can't even think of the last time I was maybe made fun of on the street, like noticeably. I'm sure it happens, but I receive way more positive than negative, but the negative always sticks out because...of how much I project.

As participants realized that no amount of policing themselves was going to mediate ongoing discrimination, and as they struggled with their mental health and projections about what other people were thinking, they began to separate from their bodies.

Disembodiment as Coping

Most participants spoke about disembodiment as part of coping with the daily negative messages that were a reality of moving through the world in a body that was recognized as Other. Some participants didn't even realize how disembodied they were until we began exploring things in their interview. Ruby stated, “It was hard to like try to articulate in my mind what my relationship was. Then I realized that's because I don't really have a relationship with my body...I feel like I exist in my body, but that it's almost not part of me”. Ahmed (2000) examined the relationship between strangers, embodiment and community. She challenges the

assumption that the stranger is “simply *anybody* we do not recognize and instead proposes that *some bodies* are already recognized as stranger than other bodies” (p. i). Ahmed (2000) goes on to say “...when we face others, we seek to recognize who they are, by reading the signs on their body, or by reading their body *as* a sign” (p. 8). Participants sought disembodiment as a way to distance themselves from their bodies being read as stranger, as an affront.

Ruby spoke about her historical disembodiment through online interactions:

In the beginning of the internet you could pretend to be anybody, and I did. I pretended to be thin...A lot of people were very interested in this person who was...well, I would not say she's everything that I'm not, because really she was me, it's just that she had a smaller body...But I've always thought that this was interesting and in the context of what we're talking about today, it's part of my relationship with my body, because it's not there.

Sunil discussed separating from his body by focusing on other identity markers, “When I put on weight, I make something else my priority. I made books and education my priority and then my career”. Sunil also spoke about how he was going through a lot of trauma in an abusive relationship at the time that he was disconnecting from his body. Diane also discussed disembodiment as a reaction to trauma:

I don't think that I've ever not been disembodied...There's this thing that is written about or talked about where part of fat pride is like live in your body, love your body and your flesh and like, you know? I could never do that because of such intense trauma that I had around my body growing up and stuff. I had to like, you know, disembodiment is such a coping mechanism for so many people with so many different histories...Your body holds so many things. My body, in my body right now is a lot of emotion that I'm not

ready to explore fully and completely. That's probably part of my need for disembodiment right now, too.

Aliya spoke about trauma and disassociating when things around her body come up, “As somebody who leaves my body kind of often, especially when we're talking about big things...I think that embodiment and being present in the room...needs to be worked on”.

Shira discussed one way of reconciling mind/body separation:

There was this thing in undergrad...where she taught us a lot about Cartesian dualism and the imagining your body as separate from your mind and that that is actually just one formulation or construct. That really changed a lot for me, because it was like I did think of my body as a separate ... Suddenly I was like, ‘Oh, my body's not separate from me. My body is me.’ So, that changed a lot for me, both in terms of being fat is part of my identity...but in a different way, not just here is my vessel that my mind is in; it's just like this is a part of me. So, since that time...I've been on a path of moving away from growing up feeling like I hated my body and that my body did not represent me.

Ella discussed making books an identity, and how that ultimately let her back to being more embodied, “That relationship between the world of books and my embodiment...that's kind of like a turning point...between just only relating to the world of books and feeling quite disembodied and being able to use that knowledge to become embodied or to recognize my embodiment”.

Several participants also spoke about overcoming disembodiment by finding joy in movement. Ella stated:

It's so weird to feel good moving my body, but I never had that experience before and now I'm having it, and I feel like I could have maybe gotten there sooner if I hadn't just

been like, 'Your body is a problem, your body is only a problem. Don't think about what your body can do. Just objectify your body.' And if I had been able to be a subject in my body sooner and look at it from a perspective of, what can you do and what do you want to do and how are you feeling?...I went from hyperfocused on objectifying my body to just being like, 'I'm not going to deal with my body. I'm just going to pretend it's not there.' And now I'm kind of coming into like, having a subjectivity that's embodied.

Conclusion

Participants experienced ongoing discrimination and harassment when navigating public spaces, in the workplace, while trying to find clothes, from their family, and when dating or in partnerships. Participants attempted to cope by internalizing the messages and policing themselves and their body. Participants also coped by becoming disembodied and trying to play up other identity markers. The next chapter will discuss how the process of becoming embodied and depersonalizing negative messages often began as participants started to claim fat as an identity and to engage with the fat community.

CHAPTER FIVE: FAT POLITICS

As the previous chapter outlined, fat people commonly experience political, psychological, social and physical exclusion in the world (Cooper, 2016). Most participants spoke about the importance of framing fatness as a political identity and finding a fat community of like-minded people as important ways to combat exclusion and stigma. Engagement with fat activism, fat politics, fat communities, fat literature, fat fashion and the creation of fat art and fat performance can help reduce feelings of isolation and shame. Though engagement with the fat community is often hailed as a singular answer to combatting individual and cultural fatphobia, the community itself is not without complications and limitations. Participants explore language, community, and politics in this chapter.

Describing the Body

Language matters. How we describe things is important to our identity and our sense of self. Sedgwick (1994) suggests that it is possible to “speak” your fatness, to “come out” as fat and renegotiate the “representational contract between one’s body and one’s world” (p. 230). Marilyn Wann is a prominent fat activist who believes that it is possible to reclaim fat “as a nonderogatory word, to reinscribe its meaning and, in fact, to celebrate it” (Murray, 2005, p. 268). LeBesco (2004) explores “fat talk” as a specific strategy to try and create social change. She believes that the more the word fat is heard uttered with positive connotations, the more it becomes accepted as a dialectic. Mitchell (2006) states that naming ourselves and resisting fat oppression “brings the individual fat subject or fat ally into the position of activist merely by stopping the activity of apologizing (literally and metaphorically by internalizing ideas about fat)” (p. 79). Almost all participants chose to identify themselves and describe their bodies as

“fat”. Participants like Jo described reclaiming fat as a neutral descriptor for their body, “I use the word fat. It's a descriptive word for me. It just describes what I am, which is a fat person.

How else do I describe my body?” Ella agreed:

I like to use the word fat. Politically, I think that's important. I get when people don't, but...I like reclaiming that language and making it as like, ‘This is a neutral descriptor.’ Just like tall, nobody's going to be offended if you call someone tall.

Jess discussed trying to move the word fat from negative to neutral:

The word fat had a lot of negative connotations, and now it's becoming more a reclaiming and taking it back...[I'm] trying to change my mindset to see it that way, because there are some negative things associated with it, because it was used as an attack.

Though almost all participants chose to use fat, they didn't use it all the time. Participants shifted the language around their body for different audiences. Cait stated, “I consider myself fat...plus-size is another that I say to make other people feel a little bit better about it”. Amanda discussed the challenges around the term plus-size:

I'm okay with the term fat, but...I definitely don't use it in front of everyone, because it makes people so uncomfortable...I'll use something like plus-size if I'm having a conversation with like a co-worker or something. But that term...it's so capitalist because it's really wedded to shopping and buying clothes for yourself...So I don't really like that term that much because it's identifying like where I shop versus like what my body looks like or how it feels...I know I'm avoiding a term because I don't want to make someone else uncomfortable.

Participants discussed the words that other people use for large bodies and their impact.

As Enid put it, “I realized a lot of the euphemisms are not really for you. They're for other

people. So, when other people call you large or full-figured, it's so they don't have to feel bad”.

Jess echoes this sentiment:

More mild terms were always used, like big-boned, or chubby, or these things that...didn't have as many negative connotations. So just more positive, and, 'You're cute and chubby,' and, 'You're this.' Trying to cutesy it up, I would say. It's like a sugar with your medicine kind of thing. As I think a lot of people veer away from that word, and it was used in a lot of negative ways...There's curvy. In the dating world, a lot of people use that term, and I just think that's fluff. I think it's very fluffy, and it's just annoying almost...It's just evading the fact that it's just fat. It's just what it is. Don't try to make these fluffy other words that skirt what it is...It's almost patronizing...

Ruby and Ariana highlighted how intersectionality impacts the terms people use to describe bodies. Ruby discussed that terms for the body are gendered. “Fat. I don't use the ‘O’ word. I don't use chubby or fluffy. I find that those are juvenile terms. Also, strangely feminine terms. You would never call a man fluffy”. Ariana discussed feeling that terminology around her body is always racialized as well:

I like to use the word curvy because I feel like it is a very honest representation of what my body is. I am larger. I'm thick when I'm joking around with my Jamaican friends because ‘thick’ is just a word that we use in the Caribbean. But if I don't bring the word thick to you, don't you ever dare call me thick. And people love calling me thick. They love telling me who I am...I'll reject it unless we're friends or unless it's a Caribbean thing... but I get extremely offended when people, especially on goddamn dating sites, instead of saying, ‘Hi, I'm interested in you. Can we chat?’ It's, ‘Yo, you're thick. Oh, look at them fat titties. Oh, do you have a big ass too?’ It's just all of this dehumanizing language that objectifies

me to my breast size or ... a lot of it is very racist...but a lot of it does have to do with my weight.

Nisha chose not to use fat:

I know that there's this movement of, I guess, reclaiming the word 'fat'. It just doesn't fit with me. I think because so many people use it as this sling. I just don't know if I'm all about reclaiming words, even 'slut', and 'bitch'. I'm not much into reclamation because I think that there's enough people who do not understand what that means in a reclaiming sense. I use the adjectives, large, big. I try not to use overweight. But, yeah, I think large ... I'm okay with that. I'm totally okay with that as a descriptor of my body. Fat, I don't know. Not so much. I think because so many people have hurled it so many times.

As they described their own bodies, participants emphasized that fat bodies are incredibly diverse, and that different sizes and shapes are privileged within the fat community and outside of it. Cora explored this:

Super fat is, I guess, the category that I would put my body in. I think that my body size is striking in many ways, because you don't see people my size regularly, at least I don't think so. I think that those are really powerful things for me, and ways that I frame my body that feel like they're coming from me, not from other people...Different looking too, I don't think my body fits into what is generally an acceptable fat body shape, which is a whole other level of things to come to terms with...An hourglass fat body shape, or like a bottom heavy body is generally more acceptable, especially within the BBW community, which is a community that I am heavily involved in. And my body is sort of like an inverted triangle. I'm like a linebacker in so many ways.

Diane highlights the difference of living in a medium fat body:

Fat. Then I'm also cognizant of like I'm kind of medium, I guess, medium-ish fat, I guess, in that I have those privileges...like doctors don't necessarily these days talk about that with me. I can fit into the airplane seat coming here and there was no problem with the seatbelt. I have those privileges.

Fat Community

Mitchell (2006) discusses the importance of finding spaces of resistance that are “centrally focused on revaluing the fat body as something to celebrate or seek pride in” (p. 84). Participants discussed finding fat literature, making fat friends, making art, performing, and wearing liberating clothes as ways that they connected with a fat community and fought back against dominant fatphobic messages. Creed (1999) discusses finding a sense of family through a shared identity. Mitchell (2006) describes fat centric spaces as “alternative home spaces” (p. 86). The shared identity of fatness, and the coming together in a fat community produces a chosen family, one that is often more supportive and understanding than fat peoples’ families of origin.

Literature

I had found it [Shadow on a Tightrope] at this anarchist bookstore in Winnipeg and then I was like oh, there's a different way of thinking about this, you know? That was a major moment in my life in which I understood that I could have a different narrative about my body.

- Diane

Many participants discussed the literature that started them on their fat acceptance journeys and prompted them to seek out like-minded individuals. Cait brought a stack of books to her interview:

I work at a library so when I was in beginning to think differently about my body I started to read a lot about different people's experiences and anti-dieting and just a random

selection of books that I have regarding bodies... They're really great. They've really shaped the way that I see myself now.



Figure 6. Fat Books

Jo also described their fat acceptance literature journey:

...probably about 10 years ago I read a book...called The Fat Girl's Guide to Life, by Wendy Shanker...I found Charlotte Cooper's book, Obesity Time Bomb. Then I found Kate Harding. That's the trajectory from 'I hate you and I'm going to try to diet you into submission' to 'fat is my friend'.

Ella describes not buying in to weight loss culture, and seeking books that would confirm her worldview:

...even when I started off into the bad place, I was always conflicted and ambivalent about it...I was still looking for resources about how it's not bad to be fat. There wasn't overly much around. But there was some...I read all of it and...there were two books that I remember really well. One was No Fat Chicks by Terry Poulton... it really opened my

eyes to the idea that being fat didn't necessarily have to be bad...I have a sense that the perspective she has is not one that I would share at this time. But just even the introduction of that idea was revolutionary to me...Then I think the most important one was the book *Such a Pretty Face* by Marcia Millman...It was going over the beginnings of fat positivity and size acceptance and a feminist critique of the pressure on women to be thin. Hence, 'You have such a pretty face, if only blah blah blah'...and that was really, really revolutionary.

Participants spoke about Linda Bacon's academic work around weight loss as impactful. Her work helped them advocate against weight loss with the people and practitioners in their lives.

Shae elaborated:

But yeah, Dr. Bacon's book talks about that a lot...About how there have been longitudinal studies now about this, and it's like, within five to 10 years, 95% to 98%, gain it [the weight] back, right? She has stuff in the back of her book...the open call to social workers, open call to doctors, open call ... They're all two pages long. They're very short and snappy and they direct you, if you want to learn more, to where you can learn more. I do think they're helpful.

Fat Friends

Cooper (2016) argues that community building is a form of fat activism. "To recognise oneself and others, to commit to a relationship, is a political act in a context where one's humanity is repeatedly diminished in the wider culture" (Cooper, 2016, p, 67). Cooper (2016) found that community building "enables fat people to develop social capital" (p. 60). Fat people resist ongoing fatphobia, harassment, and dominant discourses by "making connections with people who give them positive messages about themselves and severing relationships with people who

are destructive to them” (Rice, 2002, p. 177). Fat people coming together enables information sharing and the development of new identities and interests (Cooper, 2016). Participants discussed how literature about fatness, fat acceptance, and fat activism led them to online fat communities and prompted them to seek out fat people to spend time with. Shae stated, “through embracing...the word ‘fat’, it’s opened up an entire Instagram community to me that I didn’t know about...”.

Ruby discussed finding the online fat community:

The fat communities from the internet really, really helped...because I had no idea that there were other interesting women out there who were fat, because I was told that all fat women were lazy and stupid and nobody wanted to be their friends.

Participants discussed how surrounding themselves with fat positive individuals helped them feel more comfortable in their body and happier in social situations. Enid stated, “I surround myself with people who are also fat or who don’t really care as long as I’m happy with my body and I’m happy with how I’m feeling”. Ella discussed how her body feelings have gotten a lot better due to “having a community of other fat people”, which began when she met a fat woman at her new job:

I walked into the room and she was already sitting and I was like, ‘I’m going to be friends with her,’ and she’s another fat woman. I just instantly liked her as soon as I saw her, because she has such style...Oh my God, she has such a vibe, the best vibe...I was just like, ‘I’m going to make this happen.’ I was so lucky. We did become friends and then she introduced me to...all the other people and the fat friends group...since then having that support of people means that I’ve been able to keep going in really positive ways with my relationship with my body...I attribute all of that to having a strong community

where I can always go and know I'm not being judged. I don't have to look a certain way. Everyone gets it. If I have a weird interaction with somebody, I can tell people about it and they're, 'Oh, I know exactly what that's like, obviously.' It's helped so much.

Cora was the woman that Ella met at work, and she had this to say about their mutual friend group, "I've never felt judged by my friends. We all support each other in the way that we care for ourselves, so I'm lucky in that aspect. My social group is not diet oriented. I don't get the message that my body's wrong".

Shira also identified the importance of having a fat positive group of friends where she could socialize without stressing about her body:

Hanging out with the fatties is the best fucking time, because it's the only time I'm not thinking about my body. The only time I don't even think about it is hanging out in that group, because spending time around any other group of people or any other people, it's in my brain. It's in the back of my mind...every single other place I am in the world, I am thinking about my fatness and what other people think of my fatness.

Art and Performance

Participants started art projects and performance endeavors once they embraced and leaned into their fat identity. Creative and cultural expression is fundamental to fat activism (Cooper, 2016). Making things that make fat embodiment visible is socially transforming, offering new possibilities for imagining fat bodies and fat communities and taking steps towards creating change (Cooper, 2016). Shae stated, "Something just clicked that the word 'fat' was something I could play with as a piece of art as opposed to anything else...I started the actual Instagram project I've been doing...people submit pieces of art that are inspired by the word 'fat'".

Aliya was making art about her experiences in her body:

I participated in a friend's art show...The piece that I wound up making was a soft sculpture with fabric and crochet...I was trying to illustrate with soft sculpture how I imagine the inside of my body showing through the outside of my body. It's complicated, but how I imagine what's going on inside my body, because I've had so little clear diagnosis for any of my pain stuff. So, I just went sort of creatively into my brain about what I imagine the inner workings of my body actually might be. So, there's some parts showing that are sort of my skin-ish tone, and then everything else is just sort of encrusted with stuff, which is sort of how I feel...There's little charms, and there's a bunch of little mermaids sort of doing different stuff. There's cysts and chunks of stuff made out of beads...All of the things that sort of represent my body are all just sort of adaptive and created out of scraps of other things...I might have also been trying to make the sculpture concept a little more appealing and not quite as scary and I guess trying to make myself seem less scary, or my thoughts and beliefs and messages to be less scary...This is has been a good survival thing to be able to have people hear me or see me in some type of way that they can digest and in a way that I kind of want them to.



Figure 7. Sculpture 1



Figure 8. Sculpture 2

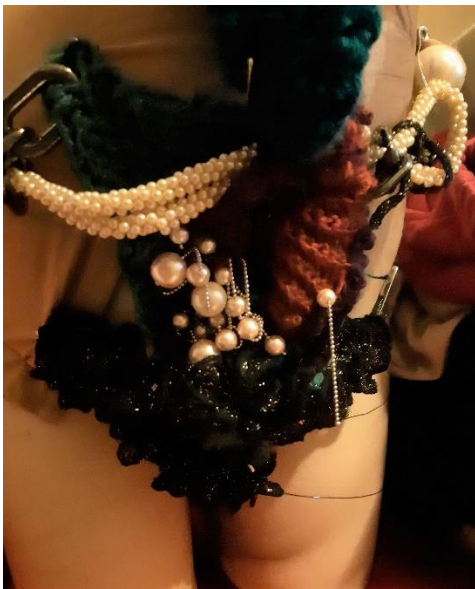


Figure 9. Sculpture 3



Figure 10. Sculpture 4

“Performance is particularly important within fat activist culture as a means of developing capital because of the immediacy of fat embodiment, its use as a reflection of fat experience, and its audiences as gatherings of fat community” (Cooper, 2016, p. 72). Enid discussed being a burlesque performer, “it was really great sort of being rewarded for the body that I had and being celebrated for the body that I had”. Enid also raised cosplay as an important part of their life that they were embracing with the body they had:

I started cosplaying as characters that don't wear full clothing...because I realized that people are going to think whatever they want to think about me anyway. All it's doing is making my life miserable, and I didn't really want to be doing that anymore... I think that cosplay and...burlesque, have allowed me to sort of access, I think, a joy of my body that I didn't have before. You can pretend to be a lot of different strong people when you're dressing up like them.

Diane chose to display art that featured fat bodies in her home because she felt it was important for her and for her children:

I...want to communicate...that because you are different in some way does not make it a legitimate thing for people to bully you. I try to communicate positive things around fatness for those reasons...I have...art hanging because I like it but also I think it is important for them to see that and understand that fatness is a type of body diversity.

Nadia discussed the importance of seeing bigger bodies in performance:

If I had grown up in a house where people celebrated my body, I might've been a dancer...I might've gone and said, ‘You know what? Fuck you. I don't give a shit how big I am, I'm going to go and be a ballet dancer.’...I love when I'm on Facebook or

YouTube or whatever and you see these dance troupes of women that size or people of size. Or you see people of all bodies doing all kinds of things. And I'm like, I wish I had that when I was a kid, because I might have felt differently...I didn't have examples.

Liberating Clothes

Fashion is “symbolic, expressive, creative, and coercive. It’s a powerful way to convey...personalities, and preferences...Fashion encourages profound rebellion and defiant self-definition.” (Jolles & Tarrant, 2012, p. 1). Fashion is also political. Fat women can use fashion as a “type of guerilla activism” and an act of rebellion against repressive beauty standards (Edut, 2003, p. 80). Cooper (2016) defines “fatshion” as central to fat activism because it can help people be more accepting of their bodies. In the previous chapter, participants spoke about not having access to clothing that they would want to wear and feeling like they couldn’t wear the things they wanted to in their current body. Many participants then spoke about getting involved in fat communities and beginning to challenge external and internalized fatphobia by wearing what they wanted to wear without worrying about their body. Several participants specifically highlighted bathing suits. Cait brought a photo of her in a bathing suit to the interview:

I think I got to a point where instead of wearing shorts and a T-shirt over a swimsuit or something like that, I just thought I would try something new and really embrace ... I really like going to the beach, so to kind of have a better experience with that...I just felt super happy and totally fine with myself...Yeah, it changed the way that I feel in public, especially at the beach. Because I think a lot of fat or plus-sized people, they're so scared that people ... Really in the grand scheme of things ... it's more about your own

experience in trying to carve out your own path, rather than looking at what other people say about you.



Figure 11. On the Beach

Several other participants brought bikinis and bathing suits. Shira and Jess explained why their bikinis were important to them:

I brought...a bikini top, because it represents how far I've come from being an adolescent under the tyranny of my mother, the tyranny of my mother's disgust with my being. There have been times when I've been able to wear this on a beach, particularly when I'm surrounded by fat people who don't give a shit...the fact that I own it at all is a big fucking deal.

I wore this on the weekend, and I've never worn anything where I was that exposed in public. It represents just pushing the boundaries of what I feel is comfortable, because I know that I want to push those things, whether it's for societal reasons, and also for myself.



Figure 12. Teal Bikini Top



Figure 13. Green Bikini Top

Ariana brought a necklace to the interview (her face has been cropped out at her request):



Figure 14. Necklace

I constantly had to be improving myself or covering up, and this necklace reminds me to just wear what I want because it doesn't really go with a high neck, turtleneck or anything like that...and just ... it's a big-statement necklace, and I'm like, 'You know what? Stop hiding so much.'

Cora also brought a necklace to our interview and discussed using the reactions that she gets from people as teachable moments. This is an excellent example of micro fat activism:



Figure 15. Venus

I brought this pendant, and it's a little Venus. It's a little goddess, and I brought this because I feel a big connection to it...I bought one for everyone in my immediate friend group, which was, I think, a cool way to ... I don't know, just have a thing that connects us, a physical thing, but also it inspires so much attention from people. Every time I wear it, people will reach for it and ask me about it. I get to tell the story, and people think it's so cool, and it's just this little fat body, and I think that's why I feel ... People being fascinated by fatness, when it's in an artistic form, but then thinking of our culture and the way fatness is so hated, the juxtaposition is so interesting to me...If I ask them, 'You love this little charm so much, and this is so similar to what my body looks like, but you

would never want to be my body,' like the fascination, the revulsion, all coming into play at once is really interesting to me. Wearing that is kind of like wearing me on me, I guess. I don't know. I like that people talk to me about it, because I'm maybe in that moment able to educate in some way, to let them know something about me that they might not know.

Cora also brought a crop top to our interview and explained about having to make a fashion transition post-injury, and letting go of control:

I have talked to you a bit about how my fashion has changed in the aftermath of my injury, and how it really became important to me to be comfortable. I think in that way I let go of a lot of control, that I was trying to exert over people's opinions of me, over my body, going from wearing things that tried to cinch in the waist that I don't have, to literally being unable to wear anything that was tight, because I was in so much pain otherwise. I couldn't deal with more, so it kind of broke me out of the tendency to try to control, and it really was, 'If I can control this body, I can control what people think about it. I won't be harassed, and I can maybe be taken more seriously at work or...'...I've never worn a crop top until this past summer, and I think that letting go of that control made me seek out things that I've wanted to wear, and things that feel free, so there's something about exposing a little bit of my stomach, and that freedom, especially in the summer, when it's really hot. It's like, 'Why am I not allowed to be comfortable?'

Ruby spoke about starting to make her own clothes out of necessity, and brought an important dress to our interview:

So this is my full sequined dress that I made a bunch of years ago, before anybody really was wearing full sequins...Once I started sewing, which happened maybe around my late

20s, because I would be going to these fat community events and all of the women there had like two stores to shop in. It was like pre-online shopping, so there would be four people wearing the same shirt there and that's ridiculous. So, I started sewing out of necessity with that and then I got better at it...finally...in my 30s I had a wardrobe that I thought actually reflected who I was, which was huge for me. Like just...I can't even explain to you...Like it used to be my wardrobe consisted of maybe two pieces of clothing that I thought I enjoyed and then the rest of it was just stupid Pennington's shirts that fit on my body that I hated, and were horrifying...when I learned to sew, it just all became amazing...To me, it was like that sorted my life and it made it okay to be in my body and to have this body, if I could represent what I wanted to for clothes...So that has been completely invaluable to me.



Figure 16. Sequin Dress

Fat Activist Struggles

“Fat activism and/or fat scholarship does not (and should not) require one to maintain absolutes” (Cooper & Murray, 2012, p. 131). Even though participants spoke extensively about the positive impact that the fat community has had on them, fat communities and fat activists are not without their struggles and limitations. Issues of size policing, racism, healthism, homogenizing experiences, and gentrifying fatness permeate fat communities. When Ariana discussed bigger and smaller fatness, she drew attention to the Othering and policing that goes on within fat activist circles:

I have a very dear friend...She loves the word fat...I call myself fat in her presence because I know what it means when I'm with her. And we both use the terms that she's big fat and I'm small fat because we are talking about the difference of being a 16 and a 22 size. And we talk about how I'm much more palatable to fatphobic people than she is...and we unpack that. And it's a very safe environment because we can unpack how bad that is and how terrible it is, but at no point is she ever shaming me for being palatable. And at no point am I ever shaming her for going to large-fat-only spaces where I would not necessarily be welcome. And we talk about the issues of Othering each other within a marginalized space.

Mitchell (2006) discusses the challenges of differently sized and shaped bodies in fat spaces:

...the need for spaces of recovery (spaces which, by definition, require bodies to have a fat history to be ‘safe’) often leaves fat activist spaces vulnerable to a kind of corporeal surveillance, in which bodies are scrutinized to see whether or not they are ‘eligible’ for recovery, or will compromise those spaces. It is in these moments and spaces that questions about whether one is ‘fat enough’ to be a fat activist often arise (p. 86).

Cooper (2016) also explores essentializing and boundary making around size within fat activist spaces. Cooper (2016) is troubled by the acts of policing boundaries to determine who is safe, when the distinction between insiders and outsiders is not always clear. Bodies are always in flux. “The mutable, fluid, human body proves problematic to a sacrosanct Fat Community delineated by fatness...” (Brown & Herndon, p. 142). The body changes, individual and cultural understandings of the body change, and other intersectional bodily markers make “belonging” even more complicated (Brown & Herndon, 2019).

Neoliberal ideals and tactics are also prompting exclusion from the fat activism movement based on gender, class, race and disability, and other intersectional factors (Cooper, 2016). Cooper (2016) argues that the gentrification of fat activism erases people of colour from the movement and upholds White supremacy. Daufin (2019) discusses that Black women’s needs frequently “fall through the cracks of anti-racist social movements and feminism” (p. 162). White fat activists touting fat acceptance and body positivity do not acknowledge experiences of bodily shamed tied to race (Daufin, 2019). “Studies and media reporting of them often compare weight stigma to racial stigma, as if there were no people of colour living in the crossroads of the two” (Daufin, 2019, p. 162). Ariana discussed her frustration with fat-only spaces, BIPOC (Black, Indigenous, People of Colour)-only spaces, and queer-only spaces being unable to make the connections to the intersections of her identity:

So, you can go to a fat session as a White person and it's about being fat, and you actually get to be heard for being fat... But when you go into BIPOC only space, then instead of us talking about being fat, we talk about being Black, about being BIPOC. And we're supposed to be talking about how skinny people of any colour are fatphobic, and how do we navigate...how do we create space for ourselves, and how do we stand up for

ourselves? And then instead of it being about that, we talk about white supremacists because we're all BIPOC, instead of talking about the intersection of being BIPOC and fat. And then we're like, 'Then we'll address the rest.' And it's like, but it's not the rest. It's very much part of it...It's marginalizing me within my own community...I'm being measured all the time, and I'm just so tired, I'm so tired.

Cooper (2016) states that as fat movements become more mainstream, marginal members are often sacrificed. Permanent and inflexible boundaries around fatness can create an environment where only a singular articulation of fatness is visible, one that privileges neoliberal and gentrifying ideals (Cooper, 2016; Brown & Herndon, 2019). Who gets to be “successful” within the movement becomes more exclusive and more exclusionary, glossing over intersectional realities. Herndon & Brown (2019) discuss fat scholars and fat activists being rejected from the community because they “reflect the messiness of human existence rather than an approved political positionality” (p. 141). “In this context I think of gentrification as a vector for loss, erasure and politically convenient forgetting that is happening in some of the most visible forms of fat activism concerned with consumerism, professionalisation, supremacy and healthism” (Cooper, 2016, p. 171).

Conclusion

Almost all participants spoke about how helpful gaining an understanding of fat politics and finding a fat community was. Many participants broke their lives down into before fat acceptance and after, and they identified how lucky they felt to be in a better place. Participants who engaged with fatness as a political identity were able to start making different choices about how they wanted to live their life. They transitioned from blaming themselves for their body size to understanding fatphobia as a structural force that they could resist in a variety of ways. A few

participants discussed the challenges of size policing and incorporating intersectional anti-oppression into fat spaces. My participant demographics demonstrate that a White, university educated, middle class population is engaging most with fat acceptance and fat activism, and we need to question who this is excluding and how we can complicate and “thicken” understandings of fatness to push the movement to be more inclusive of its most marginalized members.

CHAPTER SIX: MEDICALIZING THE FAT BODY

Chapter Four highlighted social, cultural, and relational ways that fat people receive negative messages about their body in public spaces, at work, in their families, and from romantic partners. This chapter focuses on how the fat body is medicalized and psychiatrized. Participants spoke so extensively about the negative messages that they received in medical settings that it felt necessary to give these experiences their own chapter, to properly honour the stories that participants were telling. This chapter is also a vital precursor to exploring participants' experiences in therapy. Participants who did not see private therapists saw their therapists in interdisciplinary medical settings, as part of programs in hospitals or community health care centres. On interdisciplinary health teams the referral to the therapist is often coming from a doctor or a psychiatrist who has the power to summarize the issues and outline their expectations for the therapeutic goals and conversations before the therapist even meets the client. Therefore, understanding how the fat body is read and treated (or not) within medical contexts lays the groundwork for explorations of how body work takes place in therapeutic contexts.

The ways that we conceptualize and speak about health are complex and loaded. "... 'health' is a term replete with value judgments, hierarchies, and blind assumptions that speak as much about power and privilege as they do about well-being. Health is a desired state, but it is also a prescribed state and an ideological position" (Kirkland & Metzl, 2010, p. 2). Dominant ideas about health reflect ideas about human nature, the kind of society people live in, which bodies are valued, and who counts as a citizen. Kirkland & Metzl (2010) complicate assumptions about health as a transparent, universal good by examining how health is used to "make moral judgements, convey prejudice, sell products, or even to exclude whole groups of persons from health care" (p. 2).

Robertson (1998) discusses how lifestyle choices came to dominate health discourses in Canada, emphasizing individual-level behaviour change as the most effective strategy for promoting health. "...the lifestyle approach, by neglecting to consider the social, economic and political context within which individual health behaviours are both formed and occur, essentially ends up 'blaming the victim'..." (Robertson, 1998, p. 157). Health discourses come into and go out of fashion, depending on the prevailing "social, political, and economic context within which they are produced, maintained, and reproduced" (Robertson, 1998, p. 156). In our current neoliberal context, population health is in fashion. The population health approach places faith in a purely biological, reductionist approach to health. Advocates for this position believe that data unites and theory is irrelevant. Statistics matter, not theories about how social phenomena are constructed. This ignores that health itself is socially constructed, and that access to health is not equal across populations (Robertson, 1998). The population health approach focuses on "lifestyle" as a main component of health, manifesting in health policies and public health program planning that emphasize individual-level behaviour change as the most effective strategy for improving health. Saltes (2013) states that the idea of the body as that which can be compared, measured, and improved spurred the widely held notion that there is a 'normal' way of being (p. 57). When you individualize health and make it each citizen's responsibility to enact behaviours that lead to good health there is then no imperative to examine or change social systems that may hinder access to health. If a citizen fails to have an appropriately healthy lifestyle, they are individually blamed and pathologized.

The focus on economic growth, pharmaceutical control, statistics, and a purely biological medical approach to health disappears the voices of marginalized groups. Health has become a for-profit endeavor that decides what bodies and health measures are prioritized. Health

discriminates against bodies that are considered less valuable citizens. Young (2005) argues that the dominant model of health assumes that the normal, healthy body is unchanging. “Health is associated with stability, equilibrium, a steady state” (p. 11). Young adult men are the minority who experience their health as a state in which there is no regular or noticeable change in body condition. “Medical conceptualization implicitly uses this unchanging adult male body as the standard of all health” (Young, 2005, p. 11).

Wendell (1996) describes the consequences of the cognitive and social authority of medicine as alienation, epistemic invalidation, social abandonment, failures of communication, and gaps in knowledge. Participants expressed feeling alienated from and avoiding the medical system, they felt that their knowledge about their bodies and what worked for them was invalidated or ignored. Participants also felt abandoned by their doctors when they had serious health concerns, they felt doctors didn’t communicate well, follow up, or have appropriate knowledge about providing health care to fat bodies.

Weight Discrimination from Doctors

Fat is just so pathologized that I can't imagine it not still impacting any sort of health practitioner of whatever type. That...lands on the clients that they're seeing.

- Diane

I hate being pathologized, whether it's around mental health or whether it's around my body. It's so violent. It's so violent and hateful and they don't care that they just treat us like objects and that they treat us like we're worth nothing. They don't care. The system doesn't care and it's really frightening.

- Ella

Health is a problematic concept when linked with weight. Health is not a number, but rather a subjective experience with many influences. Stepping onto a scale cannot prove a person healthy or unhealthy (Wann, 2009). However, Western societies are currently experiencing a valorization

of health that influences people and organizations (Mik-Meyer, 2010). Health policies today have been embedded with cultural values and speaking in the name of health is one of the most powerful rhetorical devices. Health has come to be viewed as a duty, and the body can be understood as a locus of power where duty and subordination play out (Mik-Meyer, 2010). Obesity is considered a loss of sovereignty over the body and has typically been regarded as “both a measure of moral laxity in the individual and sign of social corruption” (Mik-Meyer, 2010, p. 388). Yet, the idea that the body can be controlled as a widespread myth (Wendell, 1996). “People embrace the myth of control in part because it promises escape from the rejected body. The essence of the myth of control is the belief that it is possible, by means of human actions, to have the bodies we want...” (Wendell, 1996, p. 93).

The myth of control impacts how primary care practitioners view fat patients. Research has shown that physicians view heavier patients significantly more negatively and spend less time with them (Hebl & Xu, 2001). Even health professionals that specialize in “obesity” display significant implicit and explicit anti-fat biases, believing that fat people are lazy, stupid, and worthless (Schwartz et al., 2003). Almost all participants reported being marginalized by medical practitioners for failing to produce a thinner body. Participants described doctors as being gatekeepers to their access to physical and mental wellness. Participants spoke about their medical needs being ignored, and weight loss being a universal prescription regardless of the problem. Fat people have many experiences with being misdiagnosed or not diagnosed at all because medical professionals assume that the only explanation for their symptoms is their weight (Harding & Kirby, 2009). Fat people experience lifelong attempts to “cure” their bodies and bring them closer to the norm, whether that is actually best for their bodies or not (Cooper, 1997; Stubblefield, 2007). Ella discussed the difference in care for fat and thin people, “It was

just like, ‘Lose 60 pounds in like a day. Okay, thanks. Bye.’ I was like... ‘How would you treat this problem if a thin person came in with it?’” Cait stated, “...when you go to the doctor. You're like, you know, ‘I've had this pain in my leg.’ And they're like, ‘Lose some weight, the pain will go away,’ and you're like, ‘Don't think so...’”. Enid spoke about trying to access mental health care as a fat person:

For a long time, my physician refused to refer me to any mental health services because she just assumed that I wasn't necessarily depressed. I just wasn't exercising enough, or I wasn't active enough, or I was being lazy, or any number of things. So, for a long time I was struggling with things by myself, because people weren't helping me because they assumed it was tied to my weight. Weight discrimination in the medical field is a whole...area...because a lot of the times you do need a referral, and you need your doctor to be willing to do that.

Ella discussed her family doctor focusing on her weight when trying to manage her digestive issues:

My family doctor was quite fatphobic at that time. She kept insisting ... she would only give me a little bit of PPIs [proton-pump inhibitors] and then was like, ‘You have to lose weight, you have to lose weight. I'll give you a month and then you should have lost enough weight that it would help.’ It's like, are you fucking kidding me? Even if you're following what you're supposed to do, it's supposed to be two pounds per week. So, if I weigh like 260 pounds and if I come back in a month, the most I could possibly have lost is eight pounds and you think eight pounds ... so I'm going to weigh 252 pounds. And you think that's going to make a difference on this issue? Are you fucking kidding me? But no, I guess I should just crash diet and lose like 60 pounds in a month. How much

can you possibly ... that's not even physically possible, but like whatever it is. Nothing she ever said made any sense. It was bonkers.

Nadia works in the health care system with pregnant women and women who have children under 6. She described a scenario where she reported a doctor:

I think it starts in so many different ways. I worked with a woman who, her baby was a big guy, he liked to eat, he had beautiful rolls. I loved that baby; he was so cute. She took him to the doctor and the doctor was like, 'You have to put him on diet.' And I was like ... And I'm not a doctor, but I'm like, 'No, you don't.' Because before a year old, babies look all kinds of ways and they eat differently and then they start to walk and their body changes a little bit. But for a...healthcare professional to say to a new mother, 'We need to put your baby on a diet because he's too big,' that's abuse, for me, that's abuse.

And they're growing...I was like, 'Who is this doctor?' I ended up reporting him because I was like...just to imply that a baby is obese is ridiculous. But that doctor felt really comfortable saying that and really comfortable saying it to a mom...telling her to cut the amount of calories her baby takes in. And I'm just like, 'Why are we starting this now?' And then she, as a woman, had all kinds of eating issues. So that doctor's not even taking that into consideration. I'm like, 'So you've just started a whole other trend of trauma for a whole other human being because you set their parent off by being ignorant about stuff you don't know. Or you think you know, but you're not really thinking through.' So, I hear stuff like that, and it makes my insides just crawl. I can't stand that. It's just basically like, 'Fat's bad. You're fat, you're wrong, you're big, it's bad.'

When doctors assume that every problem a person is having is because of their weight and then require a certain amount of weight loss before they will act, what is really being

communicated is that they won't provide health care to people above a certain weight or size. The encounters participants described with their physicians are directly counter to the Canada Health Act, which states that all persons must have "access to medically necessary hospital and physician services without financial or other barriers" ("Canada's Health Care", 2019). Weight stigma could clearly fall under the umbrella of "other barriers", but physicians do not feel the need to remove or even challenge the barriers to care that fat people experience. This is likely because medical practitioners are so steeped in an education and clinical system that frames fatness as exclusively negative. They likely view "addressing weight issues" as a necessary, clinically competent, moral, and even kind thing to do. Margolin (1997) discusses that incredibly harmful and marginalizing interventions can and have occurred because concerned practitioners act in accordance with dominant ideals and carry out treatment plans "under the cover of kindness".

Participants felt that they were constantly being educated about the right kind of body to have, even when it was irrelevant to the reason that they had made an appointment. Health education is considered a very important part of preventing disease and promoting health. Gastaldo (1997) has linked health education efforts with Foucault's explorations of bio-power (the mechanisms employed to manage the population and discipline individuals). Health education contributes to the exercise of bio-power because it deals with the norms of healthy behaviours and promotes discipline for those who fail to achieve good health. Focusing on individual bodies or the social body, health professionals are entitled by scientific knowledge and power to prescribe "healthy" lifestyles. The clinical gaze is omnipresent, and its objective is to promote health and a disciplinary society (Gastaldo, 1997). Health education constructs identity. It builds up representations of what is expected from "healthy" and "sick" people and reinforces

these representations through complex systems of rewards and punishments (Gastaldo, 1997).

Amanda described her experiences being constantly educated about her body by different specialists:

It's going to come up. It doesn't matter how good my blood work is. It's going to come up and I just have to gird my loins, like I'm going to go in there and it's going to come up and I'm going to be like, 'Mm-hmm, cool. I'll lose 20 pounds, yeah.' I'm never going to see you again. I'm like, go fuck yourself. You just said everything was perfect. Like I don't know what you want.

Nadia described the experience of doctors trying to educate her before and during her pregnancy:

If you ever want to hate your body, go to see a doctor when you're pregnant, when you have weight on you, because the things that were said to me while I was trying to get pregnant, while I was pregnant, were really offensive. Really, really offensive, to the point where...I was like, what the hell?...So, the fact that I couldn't get pregnant was about my weight. The fact that I did get pregnant, but my pregnancy was risky, was because I had weight on me. And then I ended up having a very healthy pregnancy and I ended up having a really healthy baby...I had to make peace with myself and say... 'I can't listen to all that shit, because if I listen to all that shit then I'm going to walk into motherhood feeling shitty about myself, and then what am I going to do as a mother? How am I going to be an example?', sort of thing.

Participants described their experiences with medical practitioners who were hyper-focused on their Body Mass Index (BMI). The Body Mass Index is:

...a macro tool for normalizing the population – for taking a vast and diverse group of people and establishing a 'normal range' to which every individual bears some

relationship. Deviation from the norm is then (falsely) read as proof of behaviours that can be pathologized, just as conformity is (falsely) taken as evidence of health and good conduct. Power here thus operates both at an epidemiological level and at the level of the production of a weight-based moral identity in the individual. (Heyes, 2006, p. 133)

Deeming specific BMIs as pathological is a political rather than scientific act (Ernsberger, 2009).

The Body Mass Index not only fails to account for various physical factors, it doesn't acknowledge in any way that social factors are also very influential on bodies. Race, class, food access and nutrient intake, sleep quality, geographic location, access to quality medical care, weight cycling, and exposure to weight-based stigma are all things that can affect a person's BMI (Bacon & Aphramor, 2011; Burgard, 2009; Ernsberger, 2009; Fee, 2006). There is a growing body of literature challenging the link between BMI, disease, and death. Most studies show that people who are overweight or obese live at least as long as "normal" weight people, and often longer (Bacon & Aphramor, 2011). It is also important to note that every health condition linked to higher BMI is frequently found in people with lower BMIs as well (Burgard, 2009). The problem between picking a dividing line between "acceptable" and "unacceptable" BMIs is that it cannot be applied to individuals (Burgard, 2009). For any given BMI, there are people who are "healthy" and people who are not.

Most participants felt their doctors were lacking a holistic analysis of their health because they were so focused on weight, BMI, and diabetes that they couldn't see anything else or provide a more nuanced standard of care. Ella recalled her first childhood medical experience where BMI was discussed:

I went to the nurse practitioner for something and she was, palpating my stomach area.

I've always been apple shaped. I have polycystic ovaries. Even as a kid I was more apple

shaped but not so as you'd super notice. But anyway, I was always a bit self conscious about my tummy and she was palpating my stomach area and talking about, "Oh, I think your BMI is probably high and dah dah dah." Looking back, I think I weighed, I was my height now and I think I probably weighed 150 pounds. I weigh 260 pounds now, so it was a lot smaller, but it's still wasn't small enough for her. I remember that horrible feeling of her jabbing into my stomach with her fingers and talking about how unacceptable my body was. They're just so mean...they aren't supposed to use BMI on kids...And going from there, it was always just like, 'Don't be fat.'

Burgard (2009) discusses that BMI is discursively constructed and argues that it doesn't capture the complexity of health experiences. Nadia discusses the complexity of bodies while describing a medical encounter:

My doctors kept saying, 'Your BMI says that you're supposed to be 150 pounds.' And I'm like, 'My BMI doesn't take into consideration my bone structure. It might take my height into consideration, but not really...it doesn't take into account past trauma, or my history.' And all you're counting is like, yeah, I happen to store fat in the front of my body, but I think I'm a big believer that you can be a person of size and still be healthy. I think that that's an astonishing thing for people.

Many participants described their doctors making assumptions that they were or would soon be diabetic. Ella described her blood sugar getting tested constantly:

...every time I go to the doctor, they test me for diabetes...I mean it's not the end of the world if they're going to just test my A1C when they test everything else. I have to get my blood drawn anyway but...then I get psychological pins and needles when it comes close to the testing. I obviously have diabetic neuropathy out of nowhere even though I've

never had diabetes. But even my endocrinologist even, she was like are you sure you have polycystic ovaries because you're not diabetic? Because I was diagnosed with polycystic ovaries when I was in high school and so that's a long time to be diagnosed with that. And she was like, 'Well, since you've never become diabetic, maybe you actually have congenital adrenal hyperplasia or some kind of intersex condition.' I was like, 'Oh okay, maybe,' but I don't. I just have polycystic ovaries. But it's always the mystery of why does [Ella] not have diabetes? Like my God, I don't know.

Nadia had diabetes, and described a single incident where her blood sugar was high:

My blood sugar, I've been managing it. But then in July I did a test and my blood sugar was a little bit high, and my doctor went out on me for... Just like, 'Your blood sugar's high. You really have to watch this.' I just said to her, I said, 'Listen...In five years since I've been diagnosed, I've never had a high blood sugar once,' ...At that time in my life, somebody had passed away that was really close to me, and I actually stopped eating for a little while, and so I said to my doctor, 'Can you see the correlation between trauma and stress and high blood sugar?' It was really hard for her to answer that question...I was mourning, I didn't really change what I eat. The only time I have a high blood sugar is when this traumatic thing happens in my life, because it was my nephew that passed away, so it was close to me and really hard. She just couldn't put those things together...if we don't recognize that our brain and our body are connected...it doesn't matter how much you weigh...I think it's just always about blame and control when it comes to weight issues...Nothing is that cut and dry.

Wendell (1996) stated, "As long as the goal is to control the body, there is great potential in all healing practices for blaming the victims, and for discarding or ignoring all those whose

bodies are out of control” (p. 98). Participants spoke about feelings of being discarded and ignored, and that this often manifests when surgeries, tests, and procedures are withheld due to weight. Fat people are denied transplants, joint replacements, and elective surgery, because such interventions are seen to be “wasted” on people with higher BMIs (Harding & Kirby, 2009).

Shae described an ongoing situation with her mother:

My mom, right now, she needs knee surgery, but they will only give her knee surgery if she loses X amount of weight. It's like, well, she can't exercise because her knee hurts so fucking bad, and there's got to be other ways...even though at this point, my mom eats nothing and is still just a big person because she's a big person...I've been talking to her about, 'Okay, so ... ,' because one of the things the doctor said to her was like, 'You need to be able to stand on your knee during physio, your good knee, if you have surgery on this one.' I was like, 'Okay, so why didn't he give you that as your homework? Up how many seconds you can stand on that knee.' Now, she does that every morning, and she'll tell me, 'Okay, I stood on my knee.' I'm like, 'Okay. When you go for your six-month checkup, you might not have lost the 80-something pounds he wants you to lose, but show him that you can stand up on that knee.' I just wish that that was the focus. I hate that the solution is always like, 'Well, just lose weight,' because it is never the solution, because more and more studies are showing that when you lose weight, you just gain it back plus interest, which has been definitely my case. All prescriptions to lose weight are actually prescriptions to gain weight.

Ella wasn't given a scope that she needed to explore her ongoing digestive issues. The specialist decided that Ella didn't require it because her problems were clearly stemming from her weight:

She told me that if I lost weight it would be better because I would look nice at my wedding, because I mentioned that I was engaged. And I was like, how is this medical advice you rotten, rotten, rotten garbage person. But what I actually said was like, ‘Oh okay...my family doctor thought that maybe I needed a scope,’ and she was like, ‘No, you're just fat.’ And I was like, ‘Fantastic.’

Young (2005) describes the relationship between doctor and patient as superior to subordinate. “The authoritarianism of the doctor-patient relations increases as the social distance between them increases” (p. 13). Ella stated, “They don't want you to read the studies, they just want you to do what they say”. Ariana spoke about her intersections making it extremely difficult to get competent healthcare:

I feel like it is for three reasons, one, being a woman, two, being Black and, three, being a fat, Black, woman. Because, not only in mental health, but just all around healthcare, I have not had an easy time with it. I'm constantly told I don't know my body. I'm constantly told that I know nothing, that that's not what's happening.

Shira worked in healthcare and described her experience working as part of an interdisciplinary health team in a youth residential program, and watching fatphobia and race play out in ways that impacted the patients’ quality of care:

The nurses were these...skinny fucking assholes. All of these girls were Latina and Black. The baseline for immigrant communities and communities of colour is already fatter than these White, 1% bitches...there was a lot of anti-fat bias and healthism surrounding the girls and how these nurses would talk about them at the table...One girl had asthma, and they were like, ‘She can't make it up the stairs because her breasts are too big. She's too fat. It's weighing too much on her lungs. She can't even climb a flight

of stairs.’ It’s like, the approach was just so the wrong approach that I was hurting for these girls who had to go face-to-face with these nurses all the time. They were the gatekeepers of these girls’ medical anything they needed... They were really controlling about what the girls were allowed to eat. These girls are already so traumatized and have no control... The last thing they need is a skinny White bitch coming in and controlling their food intake. Let’s lop an eating disorder on top of all this. If you didn’t have an eating disorder when you came into that place, you definitely had one when you left.

Medical discourses position weight loss surgeries as the best solution to “obesity”, despite the tremendous amount of severe complications associated with them and a lack of conclusive evidence that they improve health (“NAAFA Policies: Weight Loss Surgery”, n.d.). Over 40% of weight-loss surgery patients have complications within three years, and one in 50 people die within 30 days of undergoing weight-loss surgery (“NAAFA Policies: Weight Loss Surgery”, n.d.). “Indeed, some fat activists see weight loss surgery as a form of genocide against fat people, the ultimate example of how the ‘war on fat’ is indeed taken out on fat people” (Farrell, 2011, p. 169). Participants experienced pressure from medical professionals to undergo weight loss surgery. Ruby spoke about trying to establish a relationship with an unsupportive new doctor:

So, I had an experience that a lot of people can identify with where I went to a medical doctor. I was trying to start a new relationship with a GP and she was very ... I almost did not open my mouth and she suggested that I get a gastric bypass and that was horrible and triggering and I started crying and then was trying to educate her, but she was having none of it. And because I was crying too, there was like this power ... I lost a lot of power. She perceived me as absolutely out of my mind when I tried to take her through reasons as to why this was not a good idea. So that was difficult.

Shae discussed that her mother had complied with medical recommendations that she get surgery, and the ultimate results:

She's had so many surgeries. She's done so much, and at the end of the day, she's still a big person...I had a fat mom who went through a stomach stapling and went through... all this other stuff, just to end up the same size she was at the beginning of all this garbage. Sure, she survived it, but at what cost? You know? She can't eat a carb without throwing up an hour later. You know? But sometimes she just wants to eat a slice of pizza with her kids. You know? That's harsh.

Fat people constantly experience being stereotyped and discriminated against, and suffer emotional trauma within the health system (Cooper 1997; Harding & Kirby, 2009; Sherry, 2004; Solovay, 2000; Stubblefield, 2007). Given the amount of fat stigmatization and discrimination displayed by medical professionals, it is not surprising that as body weight increases the rate of health care delay and avoidance also increases (Drury & Louis, 2002). Fat women cited several reasons for delaying or avoiding health care, including having gained weight since the last visit, having to get weighed when they go in, being told to lose weight, and undressing in the providers office (Drury & Louis, 2002). Several participants discussed that as result of the ongoing discrimination experienced in medical contexts, they now avoid medical encounters where possible and experience extreme anxiety in medical situations. Going to the doctor can be emotionally and physically treacherous when “there’s a one in four chance that the nurse who weighs you will find you repulsive and the physician who treats you is likely to think you’re lazy and out of control (even if she doesn’t think she’s biased)” (Harding & Kirby, 2009, p. 51).

Nadia stated, “You don't even want to go there because you're just like, ‘What are they going to

say to me?’”. Ella did not believe she would receive appropriate care if something ever went seriously wrong with her health:

So, I would say medical spaces are the worst by far. I don't trust those people. I do not trust those people at all. So that is a concern. Absolutely. That if something bad happens to me, are they just going to blame me? I don't know. Probably. Will I go anyway? I guess, but will they save me? I don't know. Hopefully. But yeah, it's not comforting. We have a system that's supposed to care for everyone, and it clearly doesn't.

Several participants mentioned that their anxiety during medical encounters threw off vitals checks or test results. Ella described getting her blood pressure taken:

I don't trust the doctor. Even when they're helpful, as soon as I go in, my heartbeat's crazy, my blood pressure is through the roof. So, then they always think I have high blood pressure because I'm so stressed out. Then I'm like, 'Okay, do it again.' And then it's fine. It's a whole thing.

Only Nisha and Ruby spoke about positive experiences within the medical system. Nisha had previously had an incredibly supportive family doctor. “She was super mega supportive. She was a very skinny woman herself. But, she was like a Black woman, so I felt like she was very accepting and understanding. She was just so good about it”. Even though Nisha had felt well taken care of by that doctor, she was anxious about needing to find a new doctor, “I'm dreading it because I'm between doctors right now, and I'm very worried that my new doctor will not be supportive”. Ruby described her shock at having a rare positive experience, when she went to the ER:

Okay, so I did have a really positive experience when I went to an emerg room, because...I thought I was having a cardiac arrest and it turned out I had some stretched

muscles. Anyway, but I went in there and I was really, really concerned that I was going to have to take a lot of bullshit, but they took my blood pressure with a large size cuff. They managed to get a blood sample with absolutely no issue. The woman, the doctor who saw me ... talked me down when I just started crying and told her what I was worried about and she gave me two gowns so that I could be properly covered. There were seats that fit me. I was like, 'Holy God, what's happening here?' So that was amazing.

Even if fat people have positive experiences in the health care system, they know that this is not the norm. Fat patients know that a good experience can become negative, and that when sent to new doctors, specialists, or surgeons there is a high likelihood that the encounters with new practitioners will not go well.

Most participants spoke about the stress of being stereotyped, automatically distrusted, and seen as a problem in the medical system. Participants felt that advocacy and micro fat activism were ongoing necessities for them as they encountered medical practitioners. Cait described the need to advocate in situations where you are already seen as a problem:

You have to be an active participant in your own care, I think maybe more so than non-plus-sized people. I think you have to really be mindful of those systems and not be so scared to advocate for yourself, but to do it, but then to also realize that it might not always work out. You might have to have the courage to say, 'This isn't working for me anymore.'

Cora described setting boundaries with her medical practitioners:

What sort of messages do I receive medically? Personally, I haven't received the message directly from doctors that my weight is the cause of everything that I go through. In the

broader medical culture, I guess, that's a message I would receive, but that makes me engage with medical professionals in a different way, so that I'm not receiving that message directly that my weight is the problem or that my body is the problem...I make it known from the start that I'm not interested in talking about weight loss, or intentional weight loss. Strategies, I don't want to hear about them. I don't want them to be part of the healthcare I receive, which is hard to do.

The College of Physicians and Surgeons of Ontario states that the values of their profession are compassion, service, altruism, and trustworthiness. The College's practice guide also requires physicians to demonstrate professional competence, collaborate and communicate with patients, and advocate for patients ("The Practice Guide", 2007). Most of the encounters here demonstrate that fat people receive a lack of compassion and service regardless of the kind of physician or surgeon they are seeing. Participants discussed that their doctors did not demonstrate a nuanced or competent understanding of fat bodies. Participants did not feel that they were collaborated with or communicated with well at all. Participants had to constantly advocate for themselves, rather than trusting their practitioner to advocate for them. Medical practitioners did not demonstrate altruistic concern for their fat patient's well being, and participants experienced them as extremely untrustworthy, believing that doctors were not interested in helping them and would just as soon leave them to die.

Psychiatry and Psychiatric Drugs

Many participants experienced psychiatry as an especially violent part of the medical system. Weitz (n.d.) argues that the psychiatric system "is not and never was a system of health or healing - it's a system of social control" (p. 1). Whitaker (2010) states that the goal of the psychiatric system is to control patients more easily. Psychiatric interventions often fail to

improve patient's quality of life, because their real purpose is to make patients quieter, easier to manage, and less hostile (Whitaker, 2010). Ella echoes this, "They just wanted me to be quiet...They just wanted me to be docile...I was so tired on that medication that they got what they wanted because I couldn't do anything. I was sleeping like 22 hours a day... All they cared about was compliance".

Whitaker (2010) argued that psychiatric drugs are often harmful to people in the long-run, and that they have many debilitating and drastic side-effects, including weight gain. Whitaker (2010) explores how harmful these drugs can be to people's physical and mental health when people are putting on "sixty, seventy, eighty pounds" (p. 285). Several of my participants had been put on psychiatric drugs and were not adequately prepared for the side effect of weight gain. Amanda described going on medication:

I have the weird experience of having been 125 pounds and 225 pounds...I went on medication for bipolar disorder when I was about 20, and I gained a lot of weight, and it was not weight you could keep off. It was like, I exercised like nobody's business. I joined boot camps. I was like, here's what I'm eating. It did not matter. It came, and when they said there would be weight gain, they did not prepare me for the fact that there would be close to 100 pounds of weight gain. That was never said to me...But it was just a like, well, it doesn't matter what I eat at this point. It doesn't matter how much I exercise. This is how I'm going to look.

Amanda went on to discuss her psychiatrist's reaction:

My psychiatrist...like the weight gain to him was just like, like he didn't even think about it. The acne, he didn't even think about it. It was just kind of like, oh yeah, that's a side effect. Whereas I think probably a psychologist or social worker would have probably

been like a little bit more in tune to like, this is going to impact you mentally. Like your mental health is maybe going to suffer if you're literally covered in acne or you're gaining weight just wildly and rapidly and like you have no control over it...he was almost blasé about it. It was just like, it didn't, it never came up. He never was like, 'Hey, like do you want to talk about this? Are you okay with it?' Like I brought it up and eventually was like, 'Hey, I have to go off this medication. I can't. Like it's not stopping. Can we try something else?' I'm like, 'If nothing else works then we can consider it. But like it's not stopping, and I don't know how bad it's going to get, and I can't keep buying clothing. This is just not working for me.'...It was just like, Seroquel is really brutal...the weight gain is not a joke...it really was glossed over when I started the medication. It...wasn't a thing that came up. I think it was kind of interesting to me, that it just didn't, like it didn't phase him at all...The fact of the matter is he should have also realized like, oh, that might make this person depressed. That's going to be hard on your psyche.

Ariana had an extremely negative experience with a psychiatrist at a psychiatric hospital in Toronto:

He was an extremely abusive therapist who diagnosed me who did not give a shit about me...he actually just had no time for me, would tell me that, 'Yeah, you're bipolar, but here are some drugs, and you should just get over your problems,'...He was just constantly like, 'Okay, well, take these drugs.'...I was desperate at that point...so I gave into his goddamn authority, and I started taking Seroquel. He prefaced it with, 'It'll make you a little hungry.'...He did not inform me that it actually would reduce my metabolism and turn my 'little bit hungry' into severe physical pain that if I wasn't constantly putting things in my stomach...it completely messed with my mind, and then it messed with my

body...I found out from another doctor that I have no metabolism anymore, and I gained 60 pounds in a month because of it...It's not an issue to be 225 pounds because there are many people that are 225 pounds either because of family history, glandular issues, by choice, by whatever reason, and they live very happy and productive lives. My problem with being 225 pounds is that it's been four and a half years now, going on five. I've not been able to get rid of the weight because it's all medical weight. My body has betrayed me, and none of this was my choice, and it was nothing that I was predisposed to... and I told him about me gaining the weight on the drugs and he's like, 'So? Go to the gym or try to eat healthier or try to do some exercise.' Just like, 'It's your problem. It's your fault.'...And that's why I say that Seroquel ruined my life...it was a realization that when I got fatter, that everything was going to be so much fucking harder because people already didn't want to believe me when I was palatable, they're really not going to want to believe me now.

Ella also experienced profound weight gain from psychiatric drugs, and she was extremely angry about the experience:

And then when I started gaining weight from the drugs, they were like, 'Oh no.' And it's like, but these drugs are mandatory. You're not going to let me not take them. And then same thing with antidepressants. Just like, 'Well, stop eating.' But it doesn't seem to make a difference. It really affected my mental health...When I was on anti-psychotics, I gained a huge amount of weight really, really quickly. Like, 30 pounds in a month. It was horrible...It sucked. It really sucked...I'm mad at them because I wouldn't have been the size I am if they hadn't given me the drugs they gave me. And then I feel like they're blaming me for something that I can't control. And also, nobody can control their size.

People are the sizes they are. But...I feel like there's something extra galling about, I followed your advice and this is what happened and now you're like, 'Screw you.' It makes me really angry.

Diane mentioned knowing people who avoided taking medication for their mental health because weight gain is a side effect. "I've known people who are like 'I probably should be on anti-depressants, but I don't want to gain weight'. I'm like, you know, probably because that's valid in the sense that the response from people will probably be so intense". Blanchette (2019) discusses that weight gain does contribute to "noncompliance" with drug regimes, because people would rather "abstain from a treatment plan than potentially gain weight" (p. 84). This demonstrates how the social undesirability and health risk discourses around fat embodiment impact people of all sizes as they are making decisions about medications and their mental health (Blanchette, 2019). Diane also spoke about dominant understandings of mental wellness and thinness as being inextricably linked:

I think it was just so ingrained that I didn't even think about it until one time I taught...a Fat Studies course...we were talking about that book...It's a really bad book. Wally Lamb, *She's Come Undone*...it's so fatphobic and it's about this person who's fat and then she's also, she has a psychotic episode and she goes into, it's in the 60s, so she goes to an institution and she loses a bunch of weight because she's getting more and more psychologically healthy. It's that kind of thing. We were talking about that in class. I remember one of my students saying 'I don't know what he's talking about. The most healthy I've felt in a mental health way is the fattest that I've been because of the drugs I was taking, and my body's response was to them was to get larger.'... my student was

just describing that we just can't imagine culturally speaking like emotional balance and mental health and well being coming in a fat body.

Sunil also discussed the assumption that thinness and mental wellness are linked:

So see I'll tell you what happens in psychiatry, unfortunately, especially in the Western world, they believe that some psychiatric ailments can be healed if you all of a sudden become a very busy body or if you indulge in exercises, which will release endorphins and bullshit theories. No. Nada. It doesn't work like that always...What you're forgetting is those same happy hormones that are releasing when exercising can backfire if you're over exercising or if you're doing that exercise as a form of transfer abuse. I was abusing my body. I was not exercising...So it's important that people understand this, psychiatry cannot always be treated with exercise. A lot of psychiatrists of mine have done this...they would tell me, 'Are you having enough exercise? Are you having healthy meal?' It's not going to magically cure me.

Dieting and Disordered Eating

“Culture not only has taught women to be insecure bodies, constantly monitoring themselves for signs of imperfection, constantly engaged in physical ‘improvement’; it also is constantly teaching women (and, let us not forget, men as well) how to see bodies” (Bordo, 1993, p. 57).

Bordo (1993) focused on the processes of surveillance and self-surveillance that create a set of normatives that bodies should conform to. Fat activists have drawn attention to and challenged the ways that food itself is moralized (Eberstadt, 2009; Harding & Kirby, 2009; Heyes, 2006; Wann, 2009). Food is loaded with meaning, a fat person eating a salad and a fat person eating a cheeseburger will be read in different ways, but all food whether “good” or “bad” carries the weight of moral significance. Over the past several decades, increasing scrutiny over the quality

of what goes into people's mouths has been accompanied by something almost wholly new: the rise of universalizable moral codes based on food choices (Eberstadt, 2009). These ideas link to Foucault's (1980) discussion of how an action is not only moral in itself: it establishes a moral conduct that commits an individual to other actions always in conformity with values and rules. For example, dieting behaviour is not simply eating "good" food once; it is a pattern of eating through which an individual establishes themselves as partaking in a mode of being characteristic with an ethical subject (Foucault, 1985; Heyes, 2006). Medical practitioners engage in practices of surveillance and control by focusing on diet and exercise, elevating a 'healthy lifestyle' (Hatty & Hatty, 1999). Dieting is a form of disciplinary control that is upheld by the medical model.

"Dieting and other weight loss behaviors are popular in the general population and widely encouraged in public health policy and health care practice as a solution for the 'problem' of obesity" (Bacon & Aphramor, 2011, p. 5). Many participants described engaging in dangerous crash dieting or developing eating disorders due to constant messaging from their doctors that they were not small enough. Ella described the aftermath of her negative encounter where the nurse pushed her fingers into her stomach:

I internalized all of that...I stopped eating for a while and I started...My goal was to eat 800 calories or less a day and I usually achieved that. I never got that skinny, well, I mean, skinny for me. Anyway, this whole time period I was weight cycling...I had a book, a calorie book that I would bring with me in my backpack and look up everything I ate. And then I had it all memorized and then I would tend to only eat the same kinds of thing, so that would be like, 'Okay, well I know exactly how much that is already.' Yeah. So, an apple was 84, which is of course it was probably random based on the size of the

apple, but you know, yeah. But I was even careful about, 'Okay, I don't want too big an apple. You can't do that.' It was so ... it was too much. It was too, too, too much.

“Many of the practices that fat people use when they diet (and which are often valorized) would be considered as eating disorders or otherwise dysfunctional behaviours in people with ‘normal’ or lower weights” (Friedman, 2012, p. 56). Participants found that disordered eating was ignored by their doctors in the quest to make them keep losing weight. Ariana stated, “I actually developed an eating disorder, which is funny because all of the attributes of the eating disorder was anorexia, but I was too fat to be anorexic because my BMI was not 17”. Ella also described not being thin enough for her disordered eating to be recognized:

It's kind of been a weird omission. In almost all of my experiences, it was kind of like my issues around food and eating and whatever. It's always just like, 'Oh, that's not an issue,' ... Like they didn't seem overly concerned about my behavior even though my behavior was actually pretty wild and definitely problematic. But because it wasn't reflected in my size... They weren't concerned at all, they never asked about my problem eating. They never asked about my problem exercise because I never got that thin, I was still normal BMI... there are pictures of me from that time and it's like holy crap. I look not like me. Like to me it looks like yikes. How did they not know something was wrong? But I guess to them they were like, 'Oh good.' Which is hurtful.

Sunil described that doctors ignored his eating disorder and continued to prescribe diet and weight loss when he was in the middle of it:

It was so bad. There were several doctors. I don't want to name names, who told me that I should lose weight because then my depression will just go away if I lose 10 kgs ... They will tell me in India, 'You can lose five or six kgs, no?' And I would be like, 'Okay. Sure.

How?' 'Work out, diet, blah, blah.' Here, it's like, 'Have you thought about indulging in some kind of rigorous activities?' 'Like what, doctor?' 'I don't know. Squash or probably skiing, ice hockey.' 'Doctor, do you mean strenuous exercises while I'm almost on the verge of collapse?' How stupid, or they will tell you like, 'Maybe you can do portion control.' 'Did you realize I am eating popcorn every night?'...Why didn't you diagnose I have an eating problem? What were you, blind? You talked to me enough to diagnose that I was having a problem.

Diane also described the silence around her eating habits:

It's interesting because no one has ever wanted to talk to me about the eating piece, as in the not eating piece and the ways that it's come and gone and the ways that I've used it over time. I think that if I was thin, that's probably what people would focus on. I've never actually, it's almost like the negative, if you want to characterize the negative experience is that no one has ever...I think I've brought it up a few times, but no one has ever wanted to engage with me on that. I actually think that I could use some work there, but no one will recognize that...I think that lack of engagement is kind of an interesting thing where it says something about how my body is read.

Chronic Illness and Disability

Several participants discussed the intersections between fatness and chronic illness or disability. When I asked participants to bring meaningful objects that related to their body experience to our interview to be photographed, several people brought items that related to medical conditions, and spoke about the items in the context of fatphobia. This demonstrated the impact that encounters with the medical system have on fat people. In many cases, participants internalized their medical encounters and carried that shame into other areas of their life. Participants were

worried about how people perceived their bodies, and they discussed how it would be easier if they were not fat. Shira wondered if thinness would make her chronic illness easier to navigate, but also viewed her body through a historical and intergenerational lens:

I always think that ... some days, I'll be like, 'Ugh, if I was only skinny, then all these other things would be easier.' I wouldn't sweat so much. Maybe my IBD [irritable bowel disease] wouldn't cause me so many problems. But it also informs in the other direction when I'm like, 'It's not my fault I'm fat. I'm fat because I have IBD, and that causes food not to be digested properly.' ...Also, talking about trauma, my grandparents...went through Auschwitz. So, the trauma of that was in my grandmother's eggs, and then she had my mom. Then my mom had me. As women, the eggs that we have for our whole life when we're born. So, the trauma of starvation and forced labor and things like that are also inside me. I know sometimes weight gain is a response to being starved...So, it's also like it's not my fault. These horrible things happened in a very not-so-distant past, and...you know?

Cora discussed concerns that her fatness makes it harder to navigate disability and health-related issues:

I've gone through a lot of tricky health things for the last year and a half that have made me a little bit more worried about how fatness plays into some of the stuff I'm experiencing, or exacerbates it, or makes it harder to heal from. It's not necessarily making me feel like I have to go out and start a diet, or go get weight loss surgery. I just think a little bit more about how much easier it might be if I weren't a fat person.

Shira brought her medication to the interview and discussed the struggle of living with IBD:



Figure 17. Mezavant

There are a lot of things my body does that drives me fucking nuts...I have my medication that I take for my inflammatory bowel disease that causes a lot of chronic pain, and it's like its own invisible disability. It's like this narrative happening at the same time. My life keeps going, but this ... It's like every time I take a step forward, it's like right there behind me. It's like my shadow. It only gets worse as I get older. It's rough...It interrupts my whole life. That's another piece of being sedentary and not wanting to be in public actually is never wanting to be caught somewhere where I need a bathroom urgently, because the symptoms are frequency and urgency...The shame and embarrassment that comes with being fat also is very bound up in having a leaky, poopy, farty body in public spaces...

Ella felt that her digestive issues were caused at least in part by a fatphobic medical system and struggled with continuing to try to manage them in the contexts of the same system:

I have GERD [gastroesophageal reflux disease] and I also have IBS [irritable bowel syndrome]...and they're stress related. And they started ... especially the GERD started

around the time that I started dieting and having those problems and I was extremely stressed out. And I also was a lot thinner and I've weight cycled a lot and it seems to not be super connected to what my weight is. But then of course as soon as I go in, they're like 'You just have to lose weight.'...They sent me to that terrible GI [gastroenterologist] doctor because they didn't want me to take PPIs anymore...But I was like, 'Okay but if I don't take the PPIs, I can't tolerate exercising at all.' Because I can't bend over at all or I throw up acid. Sorry for the TMI [too much information]. Or just sleep or function or not be in hideous pain constantly. So, if they don't do that, then what do I do? And so, they sent me to the GI doctor, and she was just like, literally, she told me that I should work on losing weight...

Jess brought pain medication to the interview and discussed how the way she walks when she is in pain draws more attention to her fat body:



Figure 18. Pain Medication

Yeah, I mean hobbling. I've been told different things. I have a cane that I could use. It doesn't really take away any of the pain, but I do end up hobbling, and that makes things move more. So, what I think ends up happening is that a lot ... I don't see myself, but I bear witness to people maybe noticing me more, because of the way that my body moves when I'm walking...having this hobble to my body... I have pain medication that helps

me move easier, if and when I need it. I don't use it often, but it is something that makes me feel...just more mobile, and more, what I consider my normal, of just being able to get through the day...with lesser pain...So it just helps to control that, and give me an element of control...

Amanda discussed the impact of the medical system only focusing on her grandmother's weight instead of managing her disability:

She was very large, and she also had a disability and she couldn't ... she ended up also having a thyroid condition but that went undiagnosed for so long, and I think part of that was just like, 'Oh, you're just fat.' It's like, oh no, she really, like someone should have been looking at this because once it gets out of check, it's just you really can't do anything about it. And it kind of turned her into a hermit...I don't think it ever clicked into me that she was embarrassed about how she looked, because she was just my grandmother. Like go outside. Everyone loves you. Everyone did love her, but she was embarrassed. It was really hard. A, it was hard for her to get around, and B, she felt like everyone was staring at her, and they often were. She was a large woman, and it just never clicked, and I feel kind of dumb. Like wow, I just didn't get that it was really hard for her to go outside.

Amanda was extremely impacted by what happened to her grandmother as she began to struggle with a disability as well. She stated, "I think it's this thing where I've been like, I can't ever let that happen to me. It doesn't matter, like not necessarily what I look like, but like if I'm in pain or something, I'm like I have to be social and do things". She also spoke about her frustrations with her disability:

I can't exercise the amount I used to exercise, or I have to do very different exercise, and that's never something anyone talks to you about when you're thin, but it is something

people talk to you about ad nauseam when you're fat. And the guilt when you're fat is just way more. So that is complicated, because when I hate my body, it's usually because it's not behaving in a certain way. It's because I'm in pain or it's like I can't do the thing I want to do.

Shae brought deodorant to her interview and discussed a diagnosis she had been coping with silently because of internalized fatphobia and fears that doctors would blame things on her weight:



Figure 19. Lavilin Deodorant

My second item is Lavilin deodorant. I had a really embarrassing condition about four years ago. I have had it since I was a teen. It's called hidradenitis suppurativa...basically what it means is that my armpits were covered in zits all the time, like just big boils. They were super disgusting...and I would use Oxy pads at night, and I would try everything to clear it up. But it was one of those things that I kind of just hitched to the idea that when I lose weight, that will go away. I only have that problem because I'm overweight. If I wasn't overweight, I wouldn't have these zits, ergo I'm never going to bring it up with the doctor...Fast forward to about four or five years ago. I'm getting a full physical...She also does...the breast self-exam. Then she's like, '[Shae], what's going on over here?' I

was just like, 'Oh, those are my armpit zits. Don't worry about that.' She was like, 'Aren't you worried about it? Doesn't it hurt?' I'm like, 'Yeah, but they'll go away when I lose weight.' She was like, 'Oh my God, [Shae]. You have been my patient for three years and you've never brought this up. I can't believe it.' Because, again, as a fat person, I never have my arm pits on display. I'm always wearing a T-shirt or a sweater or both, even if it's hot. You know? She got me to a dermatologist. Dermatologist did some tests...I have an allergy to traditional deodorants...I just can't image that if my doctor hadn't noticed it while doing my breast exam, I would still be here five years from now, today, probably with some Kleenex under here. I had all this gauze. I had all these strategies to treat my armpit zits, which I thought were an offshoot of my weight, that were really just an offshoot of a product allergy.

Conclusion

Aphramor & Gingras (2011) question whether weight management advice is ethical if it is functioning to uphold contemporary norms that value thinness. Even though medical practitioners of all kinds brought weight loss recommendations into interactions with fat patients, the literature does not support that weight loss has a positive impact on health. Bacon & Aphramor (2011) discuss the negative impacts of weight cycling, which is far more common among fat people attempting to lose weight:

Weight cycling results in increased inflammation, which in turn is known to increase risk for many obesity-associated diseases. Other potential mechanisms by which weight cycling contributes to morbidity include hypertension, insulin resistance and dyslipidemia. Research also indicates that weight fluctuation is associated with poorer cardiovascular outcomes and increased mortality risk...It may be, therefore, that the

association between weight and health risk can be better attributed to weight cycling than adiposity itself (p. 8).

Several participants described an improvement in their health metrics when they stopped weight cycling, even if doctors were still telling them to lose weight. Ella discussed her cholesterol:

I think it's really interesting since I stopped weight cycling, my cholesterol has gotten way better. My cholesterol is actually good now and it was never before...I also changed my diet because I have to eat gluten free because of my stomach problems and IBS-D. And not just gluten free, I'm not allowed a whole bunch of other stuff that are trigger foods for my GERD especially. But overall, I certainly don't think I'm eating less calories, although I don't count. And I would have thought that my cholesterol would've gotten worse because some of the very fibrous foods that I used to eat, I can't eat anymore. But all my blood work came back way better...And I feel like it was reassuring to know that my body is doing its job, things are going well.

Bacon & Aphramor (2011) also contend that attempts to lose weight result in increased risk of premature death amongst fat folks. They also reviewed longitudinal studies of weight loss and concluded that almost all weight lost through weight gain attempts is regained within 5 years, and that dieters often end up heavier than when they began the attempt to lose weight. A weight-focused paradigm is not only ineffective at producing thinner, healthier bodies, but it is also damaging. It contributes to food and body preoccupation, reduced self-esteem, eating disorders, and weight stigmatization and discrimination (Bacon & Aphramor, 2011). Bacon & Aphramor (2011) found that “promoting body discontent...induces harm, resulting in less favourable lifestyle choices” (p. 15).

In this chapter participants described the harm that had come to them at the hands of medical practitioners who were supposed to be caring for them. Participants' lived experiences clearly demonstrated that medical attempts to educate and discipline their bodies did not work. Participants suffered poor health outcomes and increased anxiety in medical situations. They developed eating disorders and gained more weight due to weight cycling and restrictive eating habits. Participants were barred from accessing medications or procedures that would have improved their quality of life because of their weight. Since participants experienced weight loss as a prescription for any medical issue or symptom they ever raised with their doctor, they did not believe that their voices would be heard, or that their health concerns would be taken seriously. Participants didn't raise health issues they were really struggling with due to fear of weight discrimination from their doctors. Participants avoided behaviours that improve health such as intuitive eating and pleasurable body movement, because those behaviours had become associated with the violence inherent in the health system. Participants felt that they were not seen as human beings, and that they never received the care or consideration that a thin patient would. Medical practitioners are doing harm to fat people. There is an urgent need for medical practitioners to change their approach when dealing with fat patients, as the current weight-based health approach is absolutely failing to meet people's needs. The next chapter will explore how medicalized understandings of weight and health also impacted participants' encounters in therapy.

CHAPTER SEVEN: EXPERIENCES IN THERAPY

In the previous chapter, participants described how they and their fat bodies were treated in the context of the medical system. In this chapter, we explore how participants are treated in therapy. Doctors and therapists work often work together within systems that assume that fat people need to change. The therapeutic role is focused on managing the psychological component of fatness. Fatness is conceptualized as “a disease of the will, a psychological pathology” (Mik-Meyer, 2010, p. 388). “Viewing overweight people as having a problematic psyche, i.e. as being weak willed, out of control, lacking self-discipline, etc., makes working with these individuals’ psychological situation ‘natural’” (Mik-Meyer, 2010, p. 389).

“Obesity” is included in the American Psychiatric Associations’ (APA) fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (Blanchette, 2019). Chapter Two discussed how the eugenics movement sought to preserve Whiteness and reflects what the socially powerful believe about morality, deviance, intellect, and civilization. Diagnoses in the DSM are also often “grounded in social discourse of immorality that pathologizes difference from white heteronormative cis-gendered colonial ideals” (Blanchette, 2019, p. 87). The DSM is another tool to position fat bodies as deviant. The BMI classifies the body and the DSM classifies the mind. “Inclusion of obesity in the DSM-V marks an attempt to solidify a biomedical relationship between obesity and mental illness, such that fat embodiment is surveilled and punished as physical and mental deviance” (Blanchette, 2019, p. 79). Further, obesity is the only condition listed in the DSM that does not “pertain to behaviour or trauma, but to physicality and appearance, suggesting it is the only embodiment that can be directly linked with mental illness” (Blanchette, 2019, p. 81). Assigning a psychiatric diagnostic label to obesity

pathologizes fat bodies as out of control and dangerous and justifies treatment plans based on disciplining embodiments that are considered abnormal (Blanchette, 2019).

The therapeutic relationship, carried out by social workers and others in the “helping disciplines”, is a way to manage people through motivating them to adopt normative societal views and behaviours (Epstein, 1999). Therapy creates a social space that is “a major apparatus for enforcing the ideology of personal responsibility...” (Epstein, 1999, p. 10). Therapy is another location where capitalist and neoliberal ideals of individual responsibility, will power, control, self-governance, and restraint are enforced. Dominelli (2002) suggests that we are being overwhelmed by a “predatory capitalism which greedily ingests those who do not subscribe to its tenets and then spews them out as worthless garbage” (p. 3).

Fawcett et al. (2005) argue that social work is inescapably organized by, even as it organizes, modern power. Therapy is a particularly insidious space where power relationships play out and normative expectations are enacted, because therapists’ actions are “enveloped in terminologies of benevolence and self-sacrifice” and are not recognized as forms of power (Margolin, 1997, p. 21). Therapists accomplish their purposes by dominating their clients, though this is concealed by an interpersonal relationship that is supposedly democratic and egalitarian (Epstein, 1999).

Therapists suggest that individuals “have *work* that they need to do, that therapy *is* work, and that in doing this work...people display themselves as doing what society expects of its members” (Foote & Frank, 1999, p. 168). Therapy aims to “restore, rehabilitate, reconstruct, and enhance” (Epstein, 1999, p. 23). Through these aims, we clearly see how the body becomes a site of focus. Karasu (2011) recommends that psychiatrists “not only discuss, but also monitor, their patients’ weight as part of every psychiatric evaluation and treatment” (p. 22). Weight loss can

be seen as an attempt to restore the fat body to a thin body, therapists aim to rehabilitate a fat person into a person who makes good decisions, who is in control of reconstructing and enhancing their body and identity. It is assumed that engaging in this body changing work will also restore and enhance mental wellness. Mik-Meyer (2010) found that weight-loss programs claimed that participants would also go through positive psychological development. Friedman (2012) argues that social workers and therapists must be able to consider individual experiences and contextualize these experiences within systems and structures, and that it is especially important for these professionals to consider “the implications of bodies that are perceived as deviant on the basis of size” (p. 53). There is a need for “an incorporation of size acceptance and fat activism into social work scholarship and practice” (Friedman, 2010, p. 53). Incorporating fat activism into the therapeutic professions will resist common body-based power dynamics that get reinforced in therapy.

This chapter focuses on how body size manifests in the therapeutic experience. It looks at how therapists make weight the problem, recommend weight loss, perpetuate microaggressions, and struggle with issues of bias and countertransference. The result of therapists grappling with approaching body size is that participants either engaged in resistance which felt stressful and conflict ridden, avoided discussing their body, or had to spend extra time educating their therapists instead of receiving immediate support. Participants also experienced financial and physical space barriers to therapy, which further reinforced that they were abnormal, deviant, or powerless in the therapeutic space. This chapter also highlights participants’ examples where therapists were affirming and approached body size and weight in a nuanced and positive way. The chapter concludes with recommendations participants made to therapists about how to best approach fatness topics with clients.

All 16 participants had been or were currently in therapy. Many participants had seen a variety of practitioners throughout their lives. I asked participants about the credentials of their current and past therapists. Most participants had seen or were seeing social workers. Some participants had seen or were seeing psychotherapists. A few participants had received counselling from psychologists and psychiatrists. A lack of understanding about fatness was seen across practitioners regardless of educational background or professional designation. A few participants mentioned that social workers tended to have the clearest understanding of structural oppression, but this did not mean that they were always able to translate those understandings to fatphobia and experiences around body size. Participants used the terms therapy and counselling interchangeably throughout their interviews. In this chapter I will be using the term therapist to refer to social workers, psychotherapists, psychologists, and psychiatrists who engaged in counselling or therapeutic work with clients. I have drawn on literature from all of these fields, and when discussing the literature I will reflect the terms used by the authors. Given that a broad range of practitioners are providing mental health help and therapy, these findings are relevant to several different fields.

Making Weight the Problem

In a therapeutic relationship we're so hypervigilant about anti-oppression and homophobia and sexism and that kind of thing, that we think about maybe approaching those subjects a little more sensitively. But we don't think about body shaming and fatphobia and that kind of stuff in the same way. And I think that that definitely is a shortcoming, for sure. For sure.

- Nadia

Parton (1999) argues that new strategies of control are emerging in social work that do not focus on meeting needs, but rather on assessing and managing risk. "The new strategies dissolve the notion of a subject or a concrete individual and put in its place a concern with a combination of

risk factors” (Parton, 1999, p. 101). The fat body has already been deemed at risk by the medical model, and many therapists work in medical contexts, often on interdisciplinary health teams where dominant ideals of health are guiding principles. Due to this collaboration, it follows that the therapeutic space becomes yet another site where discipline is enacted on the fat body. Therapists make the assumption that part of the problem is a psychological weakness, thus justifying exercising more control over fat people (Mik-Meyer, 2008).

Social work is directly related to the exercise of power and helps to create new objects of concern, investigation, and intervention (Parton, 1999). “The language of...social work, while overtly a language of helping, was thus responsible for defining the polar extremes of a moral order in which Normality confronted Abnormality” (Margolin, 1997, p. 105). Jutel (2005) argues that normality serves as the guide for clinical decision-making and diagnosis. Therapists are “the arbiter of normal and their patient/client is abnormal” (Foote & Frank, 1999, p. 174). Friedman (2012) discusses that these dominant ideas of normal vs. abnormal have historically and contemporarily meant that social workers tend “to see-saw between the ideas of the poor victim whom we need to save and the immoral actor whom we need to fix” (p. 58). Neither of those options lead to an empowering or healing therapeutic encounter.

“People whose lives are embedded within oppressive relationships engage in their reproduction in and through their interactions with others. Central to these interactions are their responses to how others frame their situations...” (Dominelli, 2002, p. 11). When presented with a body that is framed socially and medically as abnormal, participants reported that therapists behaved in a manner that made their weight the problem, even if it wasn’t why they were in therapy or what they wanted to discuss. The inclusion of obesity in the DSM justifies focusing on weight because fat people can be sent to a psychiatrist based on their embodiment alone

(Blanchette, 2019). Mik-Meyer (2008) found that practitioners act as institutional authorities, and quickly frame weight as the reason for mental health crises, even when participant's explanations of their experiences differ. "This is probably because the organizational framework of the conversation...explicitly links being overweight with having psychological problems" (p. 396).

Enid elaborated on the impact of linking mental health and weight:

So, I have been interviewing therapists for a while as well, trying to find a new talk therapist. A lot of them wanted to talk about my weight and my emotional eating and things like this, and those are not things that I want to talk about, because they're not the trauma that's relevant to what's happening to me right now... When I was younger, I had a few different therapists, again, who were just very concerned that I was not necessarily depressed but depressed because I was fat. The argument is you're not fitting in, so you are sad. But I had lots of friends. I had lots of friends! I still get along with a variety of people. My being fat wasn't preventing me from living a good life. I was a competitive swimmer in school. I did gymnastics. I did ballet. I did all of the usual childhood perfectionism things, and I just was super depressed, I now know. But the insistence was that I was quitting all of these things because I didn't feel like I fit in because I was fat... So, I think just starting there was very unhelpful. I, again, was in therapy for unrelated reasons, but the fact that they were insistent that all of these things were happening because of my size, I think just kind of messed up the rest of my trying to deal with the actual trauma that was going on. But, yeah, the general consensus from a lot of my therapists was basically just, if I was a little bit lighter, I might be happier because I would fit in better. And it wasn't very helpful, because that's not what was going on. But

unfortunately, when you're told that many times, you basically decide that that's what's going on.

Nadia had seen many therapists throughout her life and had a lot of examples of how therapists had blamed her weight, rather than focusing on her trauma and history:

I've seen many therapists my life. Lots of trauma, and so I've been to therapists where it's like, 'Okay, well, if you change this, maybe your mood will be different.' And I'm like, 'Okay, so you're saying that if I'm skinnier, my mood will change, even though I have PTSD, which has nothing to do with how big my body is. It has to do with my brain.'...It's almost like just trying to tell somebody the sky is blue when they're trying to say it's green. Sometimes I've gotten really upset in sessions...I think the very first experience I had like that was seeing a school guidance counselor. I remember being in high school. I beat up a boy...he was making fun of me and my body and stuff, and so I got really pissed off, and I clobbered him. Then I got sent to guidance because I was trouble...She proceeded to tell me that if I didn't want to deal with this kind of issue that I should make changes, that I should make changes to ... because if I didn't like my body, then I had the power to make changes. It is a very troubling thing when you go to a therapist for help, or the idea is that you're getting help, and you're trying to sort through layers of stuff, and then it becomes all about your body...I think there's still so many biases around why people have weight issues. And I think people have issues because we focus so much on fucking weight.

Nadia discussed an extremely negative experience with a therapist at a queer organization in Toronto. He kept bringing things back to her weight when she was trying to discuss sexual trauma and relationship issues:

He would talk about how he works really hard on his looks because he feels like it boosts his self esteem...I was like, 'I'm not feeling this guy at all.'...And then he proceeded to say, which really pissed me off, that the issues I was having in my relationship were because of my self-esteem and my self-esteem was related to my physical appearance. And I said, 'So, not the various physical and sexual abuses I have gone through, not the various family issues that I go through. It's all about how I look?'...I was so mad.

Shae ran into weight biases when she was trying to find a therapist:

She gives me a list of five, she suggests that I do the taste test or whatever. So, I do. I actually book initial sessions with all of them. The one that I ended up going with was the only one who didn't try to bring up, 'Oh, that's why you're big,' or like when I was like, 'Oh, I'm struggling with this and that and this other thing,' they would be like, 'Okay, we'll get to your weight loss...' It was questions like that...and because I was already starting my journey of fat acceptance, it was like, 'No, I don't want to talk to you about weight loss. I want to talk to you about other stuff...'

Shae described discussing persistent size-based harassment on the TTC with her therapist right after a stranger at the station had told her to lose weight:

I walked into my therapist's office...I was in tears, and I was like, 'You know, that person is right. They're just saying the thing that everyone else wants to say and they don't have the guts to say,' and all this other stuff. It was just really a lot. Then at the end of the session, he was like, 'I'm still charging you full price for this session, but know that I think this was a waste of your time. You just cried to me over something that you know is a problem for yourself,' and all this stuff.

Participants generally had a hard time finding therapists that they felt they could trust around weight and body topics because of these kinds of negative experiences. Diane stated:

I feel like it's informed who I can go to. It sort of limited my choices because I don't want to go to anyone who's fatphobic and then when you ask that explicitly most people are like oh yeah, but then they don't, you know, they don't actually get what you're talking about...I don't want to go to anyone who would actually hurt me in that way as opposed to help me.

Weight Loss Recommendations

Kreuter et al (1997) found that physicians often provided nutritional and activity recommendations to visibly overweight patients, but they were far less likely to propose any such information to thin patients. This dynamic carried over from medical spaces into therapeutic ones, demonstrating how dominant medical understandings of health permeate therapeutic interventions. Mik-Meyer (2008) argued that the focus on fat people needing to change their lifestyles (often despite their currently healthy condition) allowed a 'client in need' identity to be imposed on people. Friedman (2012) states that dominant understandings dictate that instead of empowering fat people, practitioners should endeavor to make them thin.

Given that mental health professionals' Codes of Ethics cite the importance of respecting the dignity of all persons and emphasis is placed on monitoring personal biases, "mental health practitioners are unlikely to exhibit weight bias openly. Instead, they may communicate it in subtle, unintentional, and/or unconscious ways" (Akoury et al., 2019, p. 95). Several participants felt their therapists were recommending that they lose weight to improve their mental health, but this was often hard to challenge as recommendations for diet and exercise were couched in the

language of mental wellness. These recommendations highlight a clear power dynamic between therapist and client, where something harmful is being suggested under the guise of improving mental health. Margolin (1997) argues that because mental health professionals are only able to carry on activities “by remaining oblivious to [their] use of power, a critical part of [their] survival involves creating new ways to keep [themselves] oblivious” (Margolin, 1997, p. 6). One way to remain oblivious to fatphobia and the policing of body size in medical and therapeutic spaces is to discuss exercise, diet, and weight loss as mindfulness activities, beneficial to mental health. Then the violence inherent in these suggestions can be ignored.

Participants experienced recommendations for diet and exercise as microaggressions within the therapeutic space. Microaggressions are subtle, hard to address, and often unintentional expressions of negativity toward individuals due to their membership in a marginalized group (Sue et al., 2007). Microaggressions in therapy are “associated with lower ratings of counseling satisfaction and therapeutic alliance and more negative therapy outcomes” (Akoury et al., p. 95). Amanda discussed being 125 pounds and 225 pounds and she highlighted the difference in therapeutic recommendations when she became bigger:

There were always just weird things where I'm like, are you talking to me about exercise because I'm fat? Like is this a thing that you recommend to everyone, or do you just say it because of how I look? And I'll never know. Like it could genuinely be that she's just the kind of person who's like, 'I think exercise is great and it's healthy, it'll help you.' I don't know. I just know that it's coded now. It's a loaded thing for you to suggest to me for my mental health because, A., I'm coming to you and telling you like, well, I'm in pain and that's hard, but B., I'm also mentioning that I'm dancing and stuff so it's probably not a thing that you have to talk to me about...And it also is so discriminated against in terms

of like the healthcare community, that it's very hard for me to trust that someone has my best interest in mind or that they aren't fatphobic, at least even without knowing it. Like she may not have thought that way, but she also might have, and so that's hard. I think it impacts me in that sense...Also...You are not fat. You've never dealt with these things. You don't know if any of the language you're using is going to feel different to someone who is. So, I think it's hard. Yeah, it's just hard. It's a trust thing, right?...I also think it's really weird that after like seeing so many mental health professionals over the years, no one really brought up exercise until I was fat like a treatment option. It's like, that never came up. No one thought about it. So, whether it's a coincidence, I don't know, but it definitely, it didn't escape me.

Ella also experienced her therapist making recommendations for yoga and other physical activities:

I don't think she's thinking about like what kind of yoga would even be accessible to a plus-sized person or a fat person. Like, that didn't seem to be like, on her kind of radar at all. And so, she would never say anything directly about my size usually. But like occasionally...there have been things. So when I lost a lot of weight she just was like, 'Oh, you look great!' Not like 'Why is this happening?' So that's like a blank spot for her. Like that's an area that like, she hasn't gotten, which we're all on our own journeys, but it would have been helpful for me to have somebody who is supportive in that regard too.

Cait stated, "I realize there are benefits from moving your body and dealing with anxiety. The end goal does not have to be, 'I'm going to lose weight.' or 'I'm going to change the shape of my body.'" In spite of that understanding, Cait had difficulty when therapists made suggestions for physical activity, "They would always bring it up and like, 'Maybe you should be more

active.’...In my brain, I was like, ‘Oh, they just want me to lose weight.’...I wasn't really super receptive to it.”

Transference and Countertransference

Transference and countertransference are important concepts within the counselling or therapeutic relationship. Transference occurs when a client redirects their positive or negative feelings from something else in their life onto their clinician, often unconsciously (Overstreet, 2018). Countertransference occurs when a clinician transfers feelings, thoughts, and beliefs onto a client. Examples of this include the practitioner offering advice versus listening to the client’s experience, inappropriately disclosing personal experiences during the session, or not having boundaries with a client (Overstreet, 2018). Miller (2000) suggests that when countertransference is taking place practitioners cannot always accurately and effectively respond to clients. Countertransference can also manifest as microaggressions in the therapeutic space. Akoury et al. (2019) discuss that marginalized groups report receiving microaggressions from their therapists, including stereotypical assumptions based on their membership in a marginalized group, over-identification with clients, minimizing or avoiding discussions of relevant experiences of stigma or marginalization, and denying the existence of systemic oppression.

Koenig (2008) discussed that when navigating fat issues with clients, “transference and countertransference may be overlooked, less acknowledged, or avoided because of the potential discomfort that may arise by addressing them” (p. 20). Koenig (2008) argued that it is important for clinicians to recognize their reactions to weight differences within their clinical relationships. Amanda discussed how the size of her practitioner impacted how comfortable she was with discussing her body in therapy:

I think the hardest thing is it's almost like impossible to trust a thin social worker to bring it up to you. And I think that's what the really tough part is, because I don't know that I could immediately just trust them... You should be mindful of what you're saying. It's going to come off in a different way than it would to someone who's thin. We just don't need the extra critique while in therapy and already vulnerable... I don't know how to create a safe space with someone who isn't necessarily fat themselves or at least fat positive themselves because it's something that you should be able to talk with a mental health professional, but I wish I knew how to do that. I just, I don't know. Like, I don't know.

Transference and countertransference issues can be managed by the clinician engaging in an in-depth examination of their cultural biases about weight and acknowledging any current body issues or past troubled body histories (Koenig, 2008). Participants experienced therapists struggling with their own body issues in ways that were detrimental to participants' progress. Sunil stated, "Don't deflect your insecurities on a person who is already a patient who has come to you and unfortunately... people do that". Jo recommended that all therapists work through their own body issues on their own time:

I just really need therapists to be aware. I need them to go to their therapist, and say, 'Hey, I've got a new person whose got all these body issues. Let's process my body issues here, so that I'm not taking them into the therapy room with this person.' Because I did a lot of processing with my therapists about their bodies, their issues. I don't think they were even conscious that they were doing it, but it was like, 'Oh, I see where we've hit your body issues here, here, and here. Do you want to talk to your therapist about this before we do this part?' I always felt like I couldn't say that, but I feel like now I could... They're dealing with their

own shit...The therapist is going to bring all of themselves into the room too. I think the whole myth of the therapist as the neutral voice of reason, that's fucking a lot to put on someone, and not true. I did a lot of babysitting. Because that's who my mom raised me to be, was the caretaker, so of course I was babysitting my therapist and their feelings in our sessions. That's what I was there to work on. Oh, anyway. It's like, fuck.

Several participants also gave examples of how their therapists brought up things about their own bodies in sessions. The narratives about practitioners' bodies often helped to support the prevailing social understanding that participants would feel better if they were smaller. Participants reported that this was inappropriate and uncomfortable. Shae discussed how she stopped working with two social workers who were focused specifically on binge eating:

One was strategies for overcoming binge eating, and she would talk a lot about how like, 'Back when I was a big person, I didn't have this quality of life that I have now,' and like, 'If only you could ...'...She brought it up a lot about how she used to be big. It was really weird, just some of the ways she brought it up and about the ways you were going to feel when you didn't binge anymore, and how your body was going to be different. At that point, I had already bought into the idea that giving up bingeing wouldn't necessarily mean I would lose weight, because I have done all that work with my nutritionist about how that's not why we stop bingeing. We stop bingeing for a lot of other reasons and don't just tie it to the, 'Because I'll be thinner if I stop bingeing,' because you might not. You might not lose a single pound if you stop bingeing...It was just some of the language she used...The other one...again, she referenced being a bigger person and how much happier she was as a smaller person. It was like, but we're literally at the eating disorder treatment center! I can't believe you would say such a thing.

Ella described her therapist discussing her own weight gain:

Like occasionally she's mentioned her own weight and like how she feels about her own body, because she's weight cycled a tiny bit, like a such a small bit. But she's very petite. So, I would imagine that like if you're used to always being the exact same size, if you gained 10 pounds, you're like, 'Oh no.' Which I'm like, if I gained 10 pounds, like okay, I don't think I would notice. But I remember like her saying specifically once like, 'Oh, like my husband and I, we're really size conscious,' like for themselves. Yeah. And I was like, huh. And I said like, 'Okay, like that's for you and that's not helpful for me,' because she was like basically talking about like how her clothes weren't fitting or whatever...I was like, 'This isn't appropriate. That's your experience and that's not my experience. And that kind of talk is like not helpful for me. Like in my journey toward trying to accept myself for who I am.' And I don't think she got that. Like I still to this day don't think she understands like size and weight as like a political thing or as an issue.

When therapists describe their own bodies it may be because they are “continually preoccupied with adjusting their behaviour so that they and other social actors can keep up and reproduce the specific social order that reflects societal norms and values, and which in this case, casts overweight and fat people as having psychological problems” (Mik-Meyer, 2010, p. 390).

Participants experienced therapists discussing their own bodies as another way of producing the expectation that clients would also want to shrink their bodies. This may also happen because therapists are struggling with their own bodies and are unable to keep that out of the session due to countertransference. Therapists need to be critically reflexive when they are doing work around body size. Reflexivity refers to the “ability to locate oneself squarely within a situation, to know and take into account the influence of personal interpretation, position and action within

a specific context” (Fook, 2005, p. 118). Practitioners are critically reflexive when they behave as “self-knowing and responsible actors, rather than detached observers” and when they are committed to challenging power relations (Fook, 2005, p. 118). It is not crucial for therapists to resolve their body feelings in order to help clients work on theirs, but therapists must recognize their issues, stay in touch with their feelings, and avoid reinforcing marginalization (Koenig, 2008).

Challenging Therapists’ Biases

Power is embodied in specific codes of knowledge and practice that give some people immediate practical power over others (Foote & Frank, 1999). “This practical power involves not only the ability to direct that other but the willingness - even gratitude - of the other to be directed” (Foote & Frank, p. 163). However, many clients are challenging the assumption that professional expertise qualifies practitioners to intervene in their lives “whilst their own experiences and wishes count for little” (Dominelli, 2002, p. 1). When participants did not display gratitude or a willingness to be directed around their body, difficulties arose in the therapeutic relationship. Participants reported that when they pushed back against what their therapists were saying, it did not go well. Shira, Aliya, Diane, and Nadia discussed that their therapists became very defensive. Shira described experiencing persistent severe anxiety over getting diabetes, and rather than working with her on how to manage that anxiety, Shira’s therapist passed on an anti-obesity resource:

One of those things I'm paranoid of is diabetes. There was a time when I was really in the height of my paranoia that I had diabetes...at the time this was coming up, I was discussing it with my therapist. She said that she had a colleague who knew lots about diabetes and sugars, and there's a certain way you can eat that helps mitigate it...She

passed me the title of a book called *The Obesity Code*. I Googled it to be like...As soon as I heard the title, I was like ... I went home, and I was like, 'No.' But then, I was feeling desperate enough that I was like, 'Okay...I'll benefit of the doubt this bullshit and see what I find out.' I can get past ... It's just a title. It's just a word. I can get past that. If it actually has the information I'm looking for that's specific to diabetes, okay. First thing I read was a review...of this book....and it was basically like, 'Put down all the other diet books...*Obesity Code* has lasting results, because it introduces a new way to diet that ensures weight loss long-term!'...The approach is that there is 24 hours in the week where you do not eat. You can either do...a 16 and an 8 separately or a full 24 hours together where it's your 'starve day' basically. I'm putting that in quotes... I'm like, 'Fuck this!'...I was like, 'This cannot possibly be what my therapist has recommended. There's no way.' She didn't look into this? Didn't the title tweak to her? Then I'm like ... I'm thinking she did look into it, and she passed it to me anyway. Does she know me not but at all?...I got super pissed. Then I had to confront my therapist...She was so defensive...I don't remember the specifics, but was basically like, 'Well, I didn't read it. I was just passing along what this other person had said, because you asked for something about diabetes...I thought it would ease your anxiety,' and blah, blah, blah, blah, blah.

Aliya spoke about seeing a therapist who was extremely negative about how she dressed. Aliya resisted by discussing how she felt good and cute in what she chose to wear:

I had a therapist who primarily worked with survivors of trauma and domestic violence or sexual abuse and those sorts of things. So, she did have a lot of things to say about the way that I expressed myself through fashion, and I wondered a lot about whether she would say the same things to someone with a different shape of body wearing the same

stuff, because at the time...I used to wear a lot of dark eye makeup and a lot of tight little dresses. I mean, it was also the time... She would also be like, 'Did you think about what you're wearing today in the world? You're having this experience, but what are you wearing while you're having this experience?', which I felt was pretty weird and kind of stuck with me, because I was always like ... well, yeah, I don't know. I thought it was strange...I'm like, 'How is wearing a little pink...dress really doing that?' She's like, 'It's jarring.'...she was just like, 'What do you think that you look like?' I'm like, 'I think I look cute!' She's like, '... Oh, ... okay.' But it was tense, a weird vibe.

Nadia resisted during a session where she was talking about trying to get pregnant:

At that time when I was trying to get pregnant or we were thinking about having a baby and he felt okay to say to me, 'Look, you can't have a baby in that condition.' I said, 'What condition are we talking about?'...He says, 'Well, generally when you're trying to have a baby, you should probably get healthy.' And then I just sat there, and I looked at him, I didn't know what to say. I was a little bit shell shocked, I don't know what the word is...And then I said to him, 'I think being shot down by you and my doctor is probably not the best thing for me.' And then he said, 'I'm just trying to guide you.' And I'm like, 'No, I feel like a piece of shit right now. But thanks.' And I just was like, 'This is a fucking shit show.'

Often therapists doubled down on recommendations for weight loss or other microaggressions after participants resisted. Because body size has been "converted into a psychological abnormality", clients are seen as untrustworthy dialogue partners when discussing their own bodies (Mik-Meyer, 2008, p. 28). "...any resistance on their part will legitimize the very 'help' (that has caused the resistance)" (p. 28). When fat clients do not connect their weight with a

psychological defect, practitioners assume their psychological problems are more serious (Mik-Meyer, 2008).

Dominelli (2002) highlights clients' potential to take action to enact transformative power. "This can occur when those who are oppressed exercise agency consistent with resisting their oppression" (Dominelli, 2002, p. 17). Participants' resistance to making weight or their body the problem are examples of clients trying to alter the prevailing social order, as therapists try and reproduce it (Goffman, 1974). Fat people who present themselves as being "wilful and in-control, or who simply refuse to accept an identity that labels them as a person with a psychological problem" are "balking at the predefined aspects of the situation" (Mik-Meyer, 2010, p. 388). Participants' refusals and resistance and therapists' responses highlight biases and power dynamics in therapeutic situations.

Avoiding the Body

Akoury et al. (2019) found that fat clients' "weight (and often associated shame or self-consciousness related to weight) made them less forthcoming, more evasive, or more avoidant in session" (p. 100). Many of my participants chose not to discuss body or fat issues in therapy. Participants cited long waitlists, a lack of time to establish trust, a short-term service where participants had more immediate crisis issues, fear of judgement, and a lack of funds to find a private therapist who was a better fit as reasons that they avoided the topic. Several participants also felt that their therapists didn't have the skills to explore issues of fatphobia in ways that would be helpful to them. Cait described why and how she reframed fatphobia discussions with her therapist:

It didn't necessarily colour the whole relationship, but there were moments where I was like I'm not going to bring this up because I already know what you're going to say...I continued it, but I changed what I wanted the focus to be. I was like 'We're going to work on this, I want more information about how I can deal with my mom being a jerk to me,' so things like that. Not necessarily the step that would make her think about my body in a different way... it's challenging to talk about those things because you have to trust the person to talk about those things...The only times that I can remember talking about my weight in a way would be when trying ... to manage my own response into how people treat me. Like in the situation with my partner's mom [being negative about Cait's size], I brought that up in a therapy session and it's more about managing with her, rather than managing my own relationship with my body... You can, again, tailor or like ... censor what you're saying and say what you want to say without meaning it. I think that is how I have done it in the past. It's like, okay, I've had these situations and deep down I know it's because of my body size, whereas I would frame it as like, oh, it's a relationship problem or it's an ongoing issue in communication or whatever it is to understand...maybe strategies for response or to set a boundary, like those types of strategies, rather than bringing in your own body experience into that.

Cait felt that she wasn't getting a holistic experience in therapy, that her mind and body were separated:

My body is like kind of blocked out of it and I don't know if that is the way that I wanted it to be or the way that the therapist or social worker wanted it to be. Yeah, it's hard to pinpoint if it was me trying to make it seem, I don't know, not less than it was, but not as connected to myself as it was...I never have looked into what their training is specifically

around fat people... That's the other thing, it could totally make them uncomfortable. I don't know. I think... it's like they never wanted to go there. They don't have the skills to go there and that's very apparent as someone who has a rough idea of what mental health services look like from a different side of it. I worked with a psychiatrist and a psychologist and I worked with a nurse practitioner and different people within the field of mental health. To see that they just don't have the skills for that in terms of a therapist and social work background ... They don't have the education or they're uncomfortable with it. I think mostly when I go for therapy or for mental health services they almost only strictly look at the ways that I'm feeling and separate them from my body. I think that's been my experience... they don't necessarily dive into that type of holistic way of looking at my mental health or my experience in the world. It's just like can you tell me why you're feeling this way or what has happened, and it's not necessarily taken into account ever... At times they don't fully understand the way that my body is perceived within society. There are a lot of negative things that I experience on a daily basis, which compound and affect my mental health in a way that is hard to explain to other people. Sometimes, I don't think they have ... They don't necessarily ever want to go there, so they keep it very limited to just thoughts, feelings and actions where your body is the vessel for all of those things but not necessarily part of your experience.

Ruby described how she and her therapist focused on strategies, rather than explicitly bringing up her body. Ruby discussed this in the context of preparing to travel, which is an enormous stressor for her:

I don't feel like we did a ton of work around 'This is my body,' and maybe we should have, because I do feel disconnected. Like maybe it's something to talk about. I would,

but I just never ... I never have...I guess, you know, like she ... I think because of the other work we've done where she knows that I want to have a good, solid plan about how I'm going to approach things, she'll say things like, 'Well, what's your plan?' And then I'll be like, 'Well, I'm going to go and I'm going to take my shoes off and I'm going to put them in the bin and I'm going to move the bin forward.' ...I don't often say things like, 'I'm too fat to fit in the fucking seat and it makes me crazy.' ...So it's almost not focused on my body as much as it is on how I deal with the situation, I guess.

Shae and Aliya both prioritized other things due to limited finances and limited sessions:

There's just so much. Because I have to pay for his time, I try to strategically use his time to deal with my parental garbage more than my body garbage, because I can get free support on my body stuff...I'm really trying to isolate his time to the behaviors that I need him to specialize on the most.

Body image stuff has not really come up, which is weird, because I've always had a body, so ... But, yeah, I think therapy's hard...Sometimes just being like the emergency of different things versus ... I've had this fat body for a while, so I tend to just be like, 'I'll just deal with it by myself.' So, yeah.

Nisha didn't bring up her body, for fear of judgement:

Maybe I don't talk about my body because maybe I do feel the threat of them judging me, and I don't want to hear it. It's a protection mechanism maybe. Maybe that's why I don't bring it up...It's a very big possibility in my case because I'm also somebody who tends to close off. I feel like the fact that I don't talk about it is probably me sheltering myself.

Educating Therapists

When therapists did not have an understanding of fat politics or size-based oppression, participants described having to do extra heavy lifting and spend time educating their therapists in sessions. Jo described the ways that this has come up with their therapists:

I have to talk about existing in the world. Often, I have to explain to whatever therapist I'm seeing the daily micro and macroaggressions I experience in the world, so they have some context for why I am how I am. In individual therapy, I'm often trying to process. I often end up back in therapy because something super shitty related to my size has happened...I have to have conversations like it's super shitty to deal with microaggressions all the time as I try to just go buy groceries, and take public transit, and walk my dog, and all this shit. I have to explain to them the context of who I am. They try to treat it on an individual level because that's what therapists do. It's really hard to have them acknowledge there's a whole world there. One of the reasons why I stopped doing therapy is because I can only fix myself so much, but I need fucking coping tools to exist in the world. I've never had a therapist who can be like, 'Here's some fucking tools, my guy. I'd be happy to help with that, because there's some garbage out there.'...Every space that I've had to navigate for therapy has had some weird narrow place that I've got to twist my body through every time, or sit in weird furniture that is not good for me. I get that whole where you have to explain how to be kind to people in the world. Fuck, I constantly have to teach people how to be just basic kind to me all the fucking time. It's exhausting. When I'm paying somebody \$125 bucks an hour, even though it's sliding scale, that's a lot of fucking money to me. Why do I have to explain to you how to be fucking kind to me? Do your own fucking research...It's like, fuck. I'm like, just go do

your fucking homework, but they'd have to do that for I don't know how many clients they have, times five days, times ... Yeah, you have to explain it to them. Then they have to tell you, 'Here's how you fix you in the context of the system.' I'm like, fuck. Not helpful.

Aliya felt that she spent so much time educating her therapist that she was not getting to what she needed to discuss:

It's been a number of months, but I only get a little tiny bit of anything out of our therapeutic relationship at the moment. I mean, it's good to talk to her, but I don't ... I think we come from very vastly different experiences, so it does feel like a lot of me explaining things. That takes up time.

Ella discussed having to educate her therapist on not discussing her own body and weight loss in sessions:

And she's said like, over the past few years, she said like, 'I've learned so much from you about like those equity kinds of topics,' which I think is really helpful. I'm not saying that I think she should be able to like put herself in the exact shoes of every person she works with, because people are so different. But to at least like, have like an awareness of the kinds of things that may be affecting her clients. I think that's important. It's what I would do if I were doing her job. I think her job would be hard, but I felt like she could've done that better...And I don't think it should be a client's responsibility to educate their therapist. And I get it, like she was new at it, relatively. Like I understand that, but like I also don't think it's very good...And I think we learn from each other. I don't think that's a bad thing and I appreciate it. Like, I appreciated that like, recognition that like she has like, taken the things I've told her into account. But I also think like there are times when

there are moments when she should have known before I told her. I don't know...Around body stuff, it hasn't happened with her. Like I've done that by myself or not really by myself, but like in our fat community with other kinds of information. And that hasn't been a part of my relationship with my therapist because she clearly doesn't get it. She's not super fatphobic but it could be better.

Ruby educated her therapist about why Weight Watchers is harmful:

I told her...that I was feeling really good because I started eating protein snack at like 4:00pm, like an egg or something, instead of sugar or carbs or something, and I just noticed...And she was like, 'Oh, yeah, oh, yeah, eggs are like one point on Weight Watchers.' And I went, 'Oh my God, Weight Watchers.' She went, 'What?' So then we had a big talk about Weight Watchers and she was really receptive to that. So, she was like, 'Oh, I had no idea.' So, she's never brought that up again, since. But she did get excited to tell me about it, but then I shut it down and she was receptive to shutting it down. So, can't really ask for much more than that ... but ... I can't forget it. Like it sticks out in my mind that that happened, because and it happened ... It only happened in the last maybe year or so, so I almost feel like, 'What the hell?' Like I mean, we've been doing all this work for like 10 years and all of a sudden you're telling me about Weight Watchers. Like even if it's secondhand. She certainly did not imply that I should go on it...but, I can't forget it. I'm not angry at her about it, but I think about it a lot.

Ariana and Nisha both discussed needing to educate practitioners not only about body size, but about racial dynamics as well. Ariana stated:

She was a skinny White woman. I don't know if it had to do with me being Black, I don't know if it had to do with me being fat. She was just dismissive...It would be very helpful

if the therapist was BIPOC or queer or both, because then there's less explaining to be done...instead of being able to say, 'This happened at work today and this is how it made me feel,' a lot of the time they were straight and White and they're like, 'Okay, so what's the problem?' I'm like, 'Well, the problem is that I'm a Black person and then this White person said this to me, and that's inappropriate,' and I have to do all this back explaining.

Cora educated her therapist about fat issues, in the hopes that she would incorporate the learnings into all her sessions:

Because of my body size, I experience messages from society in a particular way, so it comes up in my discussions with her. I'm teaching her, like I know that maybe that's not the most ideal thing in a therapeutic relationship, that the client's teaching the therapist...if what I can get is someone who doesn't challenge me on these ideas and instead who learns from me, and...learns those lessons, incorporates them into our sessions, into sessions with other people, then I think that I'm on board with sharing what I know...She does respond well. If it's a really sad discussion, she's really good at being empathetic, and validating my feelings and all those wonderful things, but what I find interesting is, because I've been so open with her about how my body effects my life, she has been more cognizant of her own, like any sort of fatphobia, she might be expressing in her own day to day life.

Diane's therapist recognized a gap in her knowledge and tried to learn more:

Well, most of my therapy was from this person in Toronto who is queer and feminist and...very much like explicitly those things...I saw her for 15 years. I think when I started to see her I don't think she really knew much about fat politics, but when I would bring it up she certainly was not, like she certainly got it because she was so, she had the

language about so many other identity politics and identity, like movements around identity. I remember, I recall one time her telling me that she had gone to a session at the Rainbow Health Ontario conference on fat politics and how like it was so good and she learned so much...She definitely was wanting, she was someone who wanted to learn and was very receptive...Yeah, so I trusted that she, when I talked about fat stuff I trusted her with that. I knew if she didn't know that she could empathize, and then also I knew that she'd be doing reading or something about it.

Cost

As discussed in the Demographics section, participants reported a wide range of incomes from under \$20000 to \$100000 annually. No matter what participants' income bracket was, none of them felt that they had the financial ability to see a therapist as often as they would have liked. Cost was a prohibitive factor to supportive mental health care, with many participants staying with therapists who were not a good fit because they couldn't afford anything else. Enid explained:

Honestly ... when you have access to free counselling and you can't afford to go see a therapist otherwise, you're going to stay, even if they're saying kind of shitty things to you that you don't agree with. So, I had the opportunity to have free counseling, and so I kept it...I think sometimes you get stuck with a person that's not a very good fit, but it's that or nothing. So, you go with that.

Cait received free counselling while she was in university, and had a therapist make a number of suggestions for her to lose weight. She remained with this person because she couldn't afford to pay for something that might have been a better fit:

I didn't end the relationship. I felt like I didn't necessarily have a choice...I think if you're paying for it, it's different because you have the choice to like ... I can move to a different clinic or work one-on-one with a different person. But you're within those clinics that are there for students or for the employee assistance programs or when you're using systems that make it more accessible...you begin to access those services or continue accessing them when you know that it's not safe or not serving your needs as well as you would want it to.

Nisha tried to access a free counselling service at a hospital in downtown Toronto, and ended up not having mental health support at all because she didn't feel she could remain with the free option and at the time was not able to afford private therapy:

... This is probably going to be judge-y, oh well. Whatever. She was like a very skinny, very conventionally attractive White woman, engaged...I was like, 'This is not where I want to be.' She was also very ... The way she talked was very ... I saw her and I was like, 'You reek of privilege, and I just don't want to be here with you. It's just not going to work.'...I went to her, and my mom went to her because she was free at the time...My mom was like, 'I did not like her. I could not relate at all.' I'm like, 'I could not relate at all, at all.'... I just stopped, I was like, 'No. I cannot go here.' My mom gave it a little bit longer, but she's like, 'As a 60 something year old Brown woman with multiple health issues, this young healthy White girl had no idea how to actually talk about the fact that...I have issues with my physical being as well that needs to be addressed into how it's impacting me mentally.'

Ariana had very negative experiences with free services, but couldn't afford anything else:

At this point, it's just very much, 'Oh, you can afford free? You can afford people who freely don't give a fuck.' And, 'Oh, you want me to pay attention to you? You're going to pay for my attention.' ...I'm trying to find safe therapy. I'm trying to find someone who can listen to my issues no matter how small, no matter how big and just be like, 'You're on the right track. It hurts, but keep pushing,' or, 'Oh no, no, no, this is really bad. This is toxic. We need to move you away from this,' and give me guidance. And I can't speak for everyone, but I feel like because therapy is so especially financially inaccessible, that it further is systematically inaccessible because people who are non-White are typically underpaid. People who are not cis are typically underpaid; people who are queer are typically underpaid. And so, all of those intersections will add up to therapy is non-accessible.

Aliya felt really constrained by her finances and wait times when it came to accessing therapy:

It was once a week for a bit, but I couldn't really afford it, so once every two weeks...I have found that, if something is affordable, it's either too far to travel or isn't really what I'm looking for in terms of how I process well ... I've found a lot of times that, when I'm in crisis or in a really bad place ... the waiting time is dangerous. I've also found that, in the places that I've been, the people who work there and the therapists actually don't know how long their wait list is. They're like, 'So, what brought you in today?' I'm like, 'Well, five months ago, this is why I wanted to be referred to you. A lot of things have changed since then. I'm kind of glad that I'm here, but five months of processing on your own, and it's a different situation.' ... Yeah. So, I found wait list and payment accessibility has really not worked out for me in the way that I want, which is true for so many other things in life, in my life and many people's lives. Yeah. I would love to have

an art therapist, let's say, but I don't have benefits that would cover that or ... And shortly, next month, I won't have any benefits. So, accessing it in a timely way and an affordable way has been really hit and miss, but mostly miss. Or being on wait lists and then just never hearing from them and being like, 'I don't know if they called and didn't know if they could leave a message, but I've indicated that they can leave a message.' But then I never heard from them for like five years. So, yeah. It's been hard to find counselling that really works well for me.

Several participants had accessed psychotherapy through schools where psychotherapy students offered reduced rate sessions so that they could fulfill the number of clinical hours required for graduation. Nisha stated, "I was looking for a therapist...her rates were only \$45 an hour. I went with her...because she was in the practicum stage of her therapy". Ella had a therapist who she felt largely positive about, but she also felt that she couldn't discuss weight and health stuff with due to size-based judgements. Ella had remained with her because she was charging less due to being a psychotherapy student:

I started seeing her because I was looking for lower cost therapy because I had no coverage...They had a referral service where you could just call and they'd find you a student...And so I started working with her...and it was only \$20 a session which I could afford, which was amazing...Would it have been better to work with someone else? Maybe, but I didn't have the resources to work with someone else.

Diane had moved to Winnipeg and was struggling to find someone with similar values. The person she did find was a psychologist and was extremely expensive:

I see her very rarely because she's so much money. Psychologists are ridiculous...Like I should be in therapy once a week, but I just can't do it. [I see her] Like maybe once a

month. Maybe, if I'm feeling particularly bad twice a month, but yeah. It's around once a month on average. She's...sort of one of the two or three queer therapists in Winnipeg that the community sees and feels safe with.

Accessible Space

Foucault (1975) argued that “discipline proceeds from the distribution of individuals in space” (p. 146). Spaces discipline bodies as they are circulated in a network of relations, such as when clients are trying to navigate healthcare and therapeutic spaces. Spaces are at once “architectural, functional and hierarchical” (Foucault, 1975, p. 156). Participants brought up the space of their therapists’ offices, often finding challenges with the location, layout, and furniture. Not fitting into the therapeutic space marked participants as Other, as a Stranger (Ahmed, 2000). Wendell (1996) argued that it is crucial to make space accessible to people with a wide range of physical and mental abilities. Enid discussed challenges in their previous therapist’s space:

My previous one was semi-accessible, but there were still stairs. It also was not set up for sort of larger people. He was...like a collector, but it makes it very hard to...navigate if there's a lot of shelves, and you're a larger person. I would say my current therapist is much more accessible, because full accessible building, there's a ramp, there's an elevator...also you have the option to use gender neutral washrooms, and it's a nice, open space. They make sure that the aisles are clear if you need to get through. The actual office is not sparse but spacious. So, I feel a lot more comfortable, because I'm a lot less worried that I'm going to break something, which is always the concern when you're going into sort of a dusty old office, crammed with books. Again, as a wide-hipped person, there's always something that's going to get knocked off somewhere...I don't think he had thought about it. I don't think it was maliciously not laid out for larger

people, but, again, I think for him it was he had a certain type of person that came to see him. I don't think I was by any means the only fat person that he saw, but I think he had a very certain kind of person, and he was expecting that everybody should be able to fit through one kind of entrance and all of this. I think that that comes from not having experience with a variety of needs of people.

Nadia struggled with fitting into chairs in her therapists' offices:

I often didn't fit into the chairs...I squeezed myself in...It's hard to be vulnerable and talk about these things in a space where you're actually not fitting...Because you know what happens to me, like when I sit in a spot and I can't sit properly? I have these visions of when I go to an amusement park and I can't close the ... or if I'm on an airplane, I can't buckle my seat, or all of this really everyday kind of stuff that is so geared to, again, smaller sized people, right?

Jo also had difficult experiences with chairs in therapy spaces, and discussed one therapist who fixed the situation:

I find the furniture I'm usually sitting on in a therapist's office has not been thought through in terms of a fat body...I think buying all that furniture is usually pretty expensive and therapists are not usually as well paid as we all think they are. I feel like I sat on some pretty shitty furniture that I'm always a little bit scared I'll break. That's always in the back of my mind...Furniture that I sit down on, and I'm like, oh, I'll just sit very still. Also, sitting on hard furniture or furniture with arms is usually difficult for me. Not great for my body...I did have a therapist specifically go out and buy sturdier furniture after I started to engage with him longer...Which was nice. He moved offices,

and he was like, 'I'm going to get a chair that's bigger, now that I think about it.' I was like, 'Cool, thank you.'

Cora had a positive experience with her therapist being accommodating around space difficulties:

It was funny because the first appointment I had, you walk into her space, it's very calming. It's in an older building...so it's wooden floors, and just really lovely to me...She usually sits on something that looks like this, this loveseat sort of thing, maybe a little bit smaller, but like a wide, comfy chair. She usually sits on that, and then she has two separate, smaller, those like cube chairs...across from her, and so when I came into the space, I kind of looked at both, and she said, 'Would you like to sit here?' She immediately offered me the large chair, and switched things around so she could see me from the smaller chairs, and it's been that way every single session. There's just been I sit there, and she sits on the other side, so very accommodating. We even had a discussion about it that first day. She's like, 'I hope ...' I think she was hopeful that I didn't take offense to being offered the bigger chair, and I said, 'No, like it was really great that you made that quick analysis and changed the situation for me.' It was nice.

Affirming Therapists

There are ways for therapists to challenge understandings and assumptions about fat bodies and the traditional power dynamics and aims of therapy. Foote & Frank (1999) argue that the way to do this is to challenge the conventional premise that problems emanate from a client's psyche and reframe the problem as being external, as being the socio-cultural story that is imposed on the client. Fat people are constructed as morally inferior with a problematic psychological situation, but therapists can help shift these narratives (Jutel, 2005). "The therapeutic task is to

open a discursive space in which clients can develop their own interpretive story - a story that affords meaning to their experiences - and to recognize how the dominant discourse works to deny this story. Thus, the therapist becomes a partner in resistance” (Foote & Frank, 1999, p 178). Prior to beginning interviews, I had expected participants to have negative experiences when approaching body size and weight-related topics in therapy, and for them to potentially leave their therapist because of that. That was not universally the case, participants’ experiences were all over the spectrum. Six participants had mostly positive or neutral experiences. Two participants had negative experiences but chose to continue working with their therapists because the rest of the relationship was positive enough to make up for one mistake or one gap in knowledge. Therefore, some participants were able to find therapists who navigated weight and body issues (or didn’t) in ways that resisted dominant narratives about body size. This resistance felt positive and affirming to participants. Shira was working through childhood size-related trauma with her therapist, and felt that even though her therapist was a very thin person, “the language and the understanding she seems to bring to it helps.”:

We are revisiting a time in my life, my 13-year-old self, where a lot of really traumatizing things were going on, including this tyranny of my mother against my body and how disgusting she led me to believe I am. So, that's coming up a lot right now in particular...She knows how big of a factor the fat stuff is in my adolescent trauma, and in my day-to-day trauma ... It's not downplayed. She elevates it ... And if I forget to mention it, she'll be like, 'And you're fat oppressed.' So, she knows. She's really good in that way...she understands that it's a large part of my emotional landscape and social location and experience.

Jo discussed having a therapist who understood fat bodies:

My last therapist...she got it about fat bodies. She was mostly working with fat folks I think. I couldn't know obviously, but the folks I saw wandering in and out of the office before and after me, there were a bunch of fat folks, which was very cool. I think someone had already done the work to educate her.

Ruby felt her therapist was respectful of her feelings about her body and weight loss initiatives:

I think she's responded well...She's not [fat] but she's always been very receptive to the things that I've brought up. I think we tackled gastric bypass really early...because I was wary that there was going to be talk about that or that she was going to tell me to get on a diet and blah, blah. She said that she would not and she asked me to tell her about gastric bypasses and she listened to me when I gave her information about success rates and then at that point, there was not a lot of research, but I had known a couple people that actually died and a couple others who like were on crystal meth and another one who had IBS. I'm like, this is just not for me. So, she was very, very good...She said things like, 'Yeah, that sounds really aggressive,' or, 'That seems like it could go very wrong.' 'It's good that you're thinking through all the things about that.' She's never suggested I go on a diet. She's never suggested I get more exercise...One time I said, 'I'm gaining weight...'. I don't remember what she said exactly, but it was like, 'unless this is causing a problem in whatever, let's not worry about it.'

Diane had a therapist for a long time who had a framework for body issues that felt very affirming:

She responded really well because she really got...I remember having so many conversations with her about shame and internalized homophobia. So, she really got that piece around body shame. Yeah, she just had that framework, right? She just knew that

stuff...certainly in terms of like body traumas and stuff like that she definitely knew her stuff. Yeah, she was pretty receptive. We also had the kind of relationship where, because we'd been together so long, ... we had that trust between us.

Nisha had positive experiences with her therapist when she talked about feeling pressure to work out all the time because she was feeling heavy:

My therapist is really kind, actually, towards it. She said, 'Be with it. Be with this heaviness. Accept it.' My problem is that I don't sit with things, I always want to move on to the next thing. I'm very type A, I'm ambitious, I'm hyper productive...I'd be like, 'I have to work out three to five times a week'. She was like, 'What would happen if you stopped working out?' I was like, 'I would just balloon up, and I would be homeless.'...I had a lot of distortions about the reality of my life. I think that's largely because of the trauma that I faced as a child, because we did experience temporary homelessness when I was growing up. I came from a very abusive household. I think all of those things impacted my distortions about what would really happen in my life. But, my therapist is always like, 'Why don't you just sit with it? Why don't we just sit with this? Think about it, think about the heaviness.'...She's very kind towards ... She's never really overtly ever addressed my weight.

A few participants had fat therapists. They highlighted this as being an important factor for them. Fat therapists can more easily play the role of witness who is "willing to hear and to see what the dominant discourse seeks to invalidate, to set apart, to silence", because participants assumed that they had a personal understanding of the invalidation that fat folks experience (Foote & Frank, 1999, p. 183). When the therapist is also fat clients may feel an instant bond and may assume that the therapist's attitudes toward their body are similar (Koenig, 2008). Clients may

also feel relieved because they assume that their size won't be judged. "Feeling mirrored by a likeness of himself or herself in a therapist perceived as competent...is often all that's needed to open the floodgates" (Koenig, 2008). Enid explained this experience:

...I currently have a very good therapist. They are also a fat person...it was very nice to walk into the office for the first time and see that they were a larger person. So, that was very constructive...It's a lot easier to talk, I think, about your problems to someone who looks like you. Because my experience had been so fat-focused in the negative ... yeah, I just felt like they would actually listen when I said my weight had nothing to do with things, because my therapists previously have been fairly, I'll say, fit people or not plus-sized people. So, they don't really listen when you tell them it's not a weight issue. But when you're talking to another fat person, you're like, 'No, that's not what this is about.' They're like, 'Oh yeah. Okay. Fair enough. I get it. So, let's figure out what it is about.'... And also, just, we had a conversation when I interviewed with them about the fact that I am fat, and I do sex work, and all of this other stuff. They were like, 'Okay, great.' Just no reaction. I was like, 'Perfect. You're the therapist for me.' Not being prejudged. I think, again, just the fact that I can talk to a fat person about the fact that it's not my fat and have them hear and believe me has been very, very helpful...So, we're having an easier time because I feel like I can trust them.

Jo specifically sought out therapists who were fat:

Most of my therapists have been ... Even subconsciously when I was younger, I chose folks who were fat. I pretty much never had a really thin therapist. My mom took me to this child therapist when I was 15 because I was too angry, and she didn't know what to do with me. It was so funny because the therapist spent the whole time validating me. Her

name was Peggy. She was great...she was fat. I got lucky, my mom picked someone who was not a slender person. Thank God.

How to Approach Fat Discussions in Therapy

Friedman (2012) discusses that Canadian social workers are bound by their Code of Ethics to oppose prejudice and discrimination against any person or groups. Therefore, social workers and therapists “have a responsibility to pay attention to the experiences of fat people and participate in (if not become leaders of) the fight against fat-phobia” (Friedman, 2012, p. 56). Participants had many recommendations for how therapists could best approach discussions of fatness, weight, and body size in ways that challenged individual and systemic fatphobia. Participants discussed that therapists needed to avoid automatically linking mental health with body size. Participants wanted therapists to access education so that they could better understand fatphobia as a legitimate form of oppression and provide appropriate fat acceptance/body positivity/body neutrality/Health At Every Size (HAES) resources. Participants did not want their therapists to bring their weight up as a problem, they wanted to be the ones to discuss their body if it felt necessary. Participants who had difficulty discussing their bodies felt that neutral questions about body feelings on intake forms or body positive materials on the walls or around the office would encourage them to take that step. Participants discussed that diet and exercise recommendations from their therapists were loaded and often unhelpful. Participants also emphasized that it was important for therapists to integrate individual and structural approaches to body experiences, as approaches that were too individually based or too structurally conceptualized were not helpful. Diane cautioned against linking mental health with body size:

This conflation right now that we have between mental health and body size is a real issue. It's a real thing. The pathologization of fatness in terms of mental health I think

that...people experience it a lot from their practitioners. I would say ideally that would not happen...Their psychological lives are of course influenced by the social responses to various body sizes and that's going to be different depending on how large or small they are. Sort of tackling that ... Figuring that out and negotiating that and understanding how that translates into things like anxieties and depressions and other stuff. I think ideally... that's what would happen.

“Other structural fights have been incorporated into core social work teaching and knowledge, but an awareness of fat is still absent from the social work profession” (Friedman, 2012, p. 54). Participants noticed a lack of knowledge around fat issues and recommended that education was prioritized for social workers and therapists. Enid elaborated:

Recognizing that weight and fatphobia is an intersection that a lot of people live at and that it can affect how you see other forms of your identity...that it can really affect how you're presenting or how you're identifying...maybe not just putting blame on one thing but making it one facet of a multifaceted problem. So, I think just making ... even if you don't want to lay a full foundation, making people aware that these affect other aspects of people's lives I think would be nothing but helpful and also probably would increase the ability to have sensitivity training on it and how to handle it and how to handle people who are having problems with it or not having problems with it, whatever it may be. I think for sure just not making it an invisible problem anymore, making it a visible problem, and just acknowledging that some people are fat and that's their life and helping them deal with how they feel about that, whether it's positive or negative. Because I think that's part of the problem too is, if we're not talking about it, we're just pretending it doesn't exist. I don't think that's a way to go about it.

Shae felt that fat issues should be present in educational programs and that ongoing professional development opportunities should also be available to practitioners. Cait also felt that appropriate education and training was very important:

The way that people think about plus-sized bodies is definitely socially, but it's also, they think about it within a system. If we think of education and social work, for example, or all of those things, they're only going to look at different body sizes within that systematic way. Maybe there's bias within that system towards ... and it privileges different types of bodies... Within society, there is this negative assumption. It's changed a lot over the last five years with body positivity and all of that sort of stuff. Maybe educationally, they're a little bit slower to change and what happens if folks are being trained and taught or if people have done their education 10 years ago or 15 years ago, is there anything that can support them in learning and different ways to support people with different issues? I don't know. I don't know what they learn about it and I'm like maybe they don't learn anything... Yeah, definitely I think about education, curriculum, development and ongoing professional development. I've used counseling services very frequently, so yeah it's very interesting to actually think about it in this way. It's not just society telling you, but it's the services and the systems that you access and navigate through, they're relying on that same societal understanding of what different bodies are. When we create systems around that, it can be challenging to help people who fall outside of that. Yeah, training and education and having conversations, even though they're uncomfortable is, I think, the only way to fix it.

As discussed earlier, participants felt that countertransference was a particular problem around body issues as they came up in therapy. Shira had many thoughts around

countertransference, education, and best practices both as a person who sees a therapist and as a practitioner herself:

Well, like any good best practice in social work...it's not about you as the deliverer...as the practitioner. It's about the client. So, just like any other transference or neutrality or however you want to frame it, social workers need to be able to put their own biases aside and either talk to the client in a body/weight neutral way or, even better best practice, talk to the client about size and body in whatever the way they want...or have identified they need. But absolutely, at bare minimum, there needs to be a best practice across the board, and that doesn't exist...Moreover, just like how...it was like, 'Oh, this is how you're supposed to respond when someone tells you they've been sexually assaulted,' or in a domestic situation or whatever. These are the things you say, and these are the things you don't say. Then that informed, oh, I guess it makes sense why we shouldn't say this, because it sounds judgmental and we probably shouldn't be judgmental, because they're already living in fear or traumatized...Just how trauma-informed care should exist when there's trauma, fat-informed care should exist when there's fat...There needs to be a 'here's what you don't say'...I'm willing to bank that like 85 to 90% of good social workers know what to say and not say to someone who's been sexually assaulted. It should be 100%, but I doubt it is...But I can't say the same for fatness...It's changing...It's going to take a while. But it's beginning. The seeds are planted...It needs to be part of social work training at the graduate and undergraduate level, because it's not just social workers. It needs to be social service workers and case workers as well. And in particular ... I mean, all of our populations are vulnerable, but in particular with children and teenagers and adolescents. There needs to be broader education, both at the

practitioner level but also above them at the quality control level and also...at the group work, family work, and individual work level. Because social work in general accepts that there are social injustices and inequities that cause mental health problems and vice versa that cause a person to need social work. So, there needs ... Fatness needs to just be a common-sense, understood part of that melange as well.

Shae felt that therapists mirroring language is an important part of validating the experience of fat clients:

If someone uses the word 'fat,' just join them on it. Don't fight them on it. Don't say, 'Oh, I wouldn't use that word,' it's like, 'Well, then what are you saying about that word?' You're loading a lot of judgment onto it. I think that's probably the biggest thing that they can do is just accept people's terminologies, and even understand the way that someone uses 'fat' can be really powerful. If someone's calling themselves a fat piece of shit, you might want to be like, 'Oh, you're not a piece of shit. Let's work through that.' But if someone is just like, 'I'm a fat person. As a fat person, XYZ,' acknowledging that you're like, 'Oh, you are a fat person. I see you, and I do validate your experience as XYZ,' would be really helpful, as opposed to, 'Are you sure that happened? Maybe they meant this. Maybe they ...'

Most participants felt strongly that practitioners should wait for clients to bring up fatness and body issues, rather than raising it themselves. Aliya stated, "I would want for ... I would want not to have my body brought up by them. I would want to bring it up myself when I felt comfy and ready." Diane also discussed allowing clients to lead the conversation:

I think like anything else in therapy just allowing people to sort of lead the conversation, the client...and then the therapist meeting [the client] where they're at with that

and...having enough knowledge about that thing to sort to nudge them in a particular direction that might help them grow.

Jess discussed her experiences:

It was a lot of times, yeah, that pity, giving suggestions, and 'help' to people, and not letting it be something that is brought up. If I bring it up, and I talk about it, it's a totally different thing. I think allowing people to bring it up themselves, and what it means, and what it represents, and just giving us space where people can talk about it. But if it's brought up as a topic, there's going to be way more resentment, and way more of closed off resistance to, 'Oh, well let's talk about this,' and not allowing people to just come to ... I think a lot of psychotherapy to me, is allowing people to talk and come to their own conclusions, and not formulate conclusions.

Ruby described the importance of her therapist letting her arrive at the body stuff on her own:

If a therapist said, 'Are we going to talk about your weight?' Like, I think they'd freak out...I don't think you can ... You have to wait until they bring it up. I think you have to. I don't ... I can't imagine any other way that would not feel invasive and attacking. I think I would have lost my mind if she had said, 'Well, what are-' because doctors have said that to me, 'Well, what are we going to do about your weight?' ...It's like the implication, like no. Get away. Yeah. So maybe that set the stage for our relationship, actually, that she didn't. I don't think she went near it. I think she waited for me to bring it up. Yeah. But maybe even the idea that we're not there to deal with my weight. We're there to deal with my relationship to the world and creating boundaries and creating tools to help me get through the world rather than, 'Well, you should go on a run every day and eat some

eggs.’ ...She never once said that she thought I would be happier if I was thin and I have heard that people have had that experience in therapy, which is really awful.

A few participants also highlighted that while in an ideal scenario, the client would raise body stuff they wanted to talk about, that is often not easy. Amanda stated, “I think it's, like for me personally, I want to come to it on my own terms, but I also recognize that maybe I won't and that doesn't mean I shouldn't be talking about it”. Nisha also felt that she was unlikely to bring up her body in therapy, and made some suggestions as to how a therapist could approach it or make her feel comfortable enough to raise it:

Maybe you have a questionnaire, an intake...questionnaires should be how you feel about your physical being, or your body, or how you feel that ... Having open ended questions, that might be a gentle way of approaching it... Maybe have messages of body positivity on their walls...I don't know. Something like that, because I know when I went to the queer woman of colour therapy there was obviously a lot of LGBTQ stuff on the walls, it was really nice and welcoming. Maybe something like that, like ‘All bodies are beautiful.’ Or, ‘Every body is a great body.’

If therapists are going to ask clients about their body, therapists should avoid making assumptions. Enid stated:

So, I think just...starting with a question. ‘Do you think this is what's happening?’ ‘How do you feel about your body?’...‘How do you feel about these things?’ I think that's a great place to start because it allows people also to access whether or not that is an issue.

Many participants felt that their therapists were not equipped to discuss fatness with someone who wasn't attempting to lose weight. “The power of the dominant discourse is to include some stories as tellable and to exclude others as marginal and abnormal” (Foote & Frank,

1999). The story of the fat client who wants to lose weight is an infinitely tellable story, loaded with the expectations of dominant discourses and leaving room for the therapist to engage in improvement work. Participants' therapists struggled when faced with a different story. Matz (2011) states, "No matter where therapists find themselves on the continuum of size acceptance, it's our duty to become more aware of this issue and familiar with the research" (p. 10).

Therapists' struggles with the story of clients who didn't want to lose weight became particularly evident as they continued to make recommendations for diet changes, exercise routines, and other suggestions that might lead to weight loss. Amanda felt such recommendations should be approached with caution:

So, I think my recommendation would be to be aware of the fact that things they might suggest to their thin clients are going to come with extra baggage. Exercise, dietary changes, like all of that stuff... Like we don't need you bringing it up. If you're going to tell us to like stop drinking Coke, if you see us come in with a Coke, you might just want to say like, 'Hey, lay off the caffeine if you've got anxiety.' Like that's a legitimate concern. If I'm manic I should stop drinking caffeine. But if I were a pop drinker, like probably don't bring that up because I've probably been told or probably already know I shouldn't be drinking it. Like we are very, very aware of our own bodies, so we don't need you to bring that awareness.

Participants also felt that therapists didn't have appropriate fat resources for clients who were not trying to lose weight, and that they often couldn't approach fat discussions without pity. Jo stated:

I think it's the responsibility of the therapist. I know this is putting a lot of responsibility on a therapist, but they need to provide resources for folks. There aren't a ton of them, but

fucking go out and find them. Take the time, go on the internet for half a day. Find some Facebook groups. People don't know where to go, and the Facebook groups aren't necessarily secret. Reach out to your fat friends...Just because you feel bad for someone, it's not helpful. I'm not paying you to feel bad for me. You just joined the ranks of the folks who just feel embarrassed for me. Do you know what I mean?

Aliya was frustrated that she was not getting what she needed from her therapist, and expressed what she wanted:

Little skill shares or 'Here's a technique for when this happens,' or 'What would happen if...?' ... 'What do you think would happen if you tried this?' Even some suggestions. I'm not saying tell me what to do, but ... Yeah. I would also appreciate ... you just having some background knowledge about the kinds of things that affect me.

Participants also stated it is important for therapists to be able to work through internalized fatphobia with clients who perhaps do come to therapy thinking fatness is bad and wanting to lose weight. Cora elaborated:

I think if the client does bring it up, and it's someone who is sort of mired in the idea that a smaller body is a better body, being able to address assumptions like that, or beliefs I guess, strongly held beliefs like that, by providing fat positive and fat activist literature, to counter those ideas. I don't know, fact sheets that showcase medical facts about fatness, and it's actually not connected, like doesn't cause all these terrible things...I mean in an ideal world a therapist would be armed with information that counters the terrible ideas that circulate our culture about fatness, so that if it does come up, and they do have a client who's berating themselves for their body size, they can say, 'We need to be gentle with ourselves, and here are the resources.'

Fook (2005) discusses contextuality as a major feature in the therapeutic relationship. Contextuality requires a “knowledge of how differing and competing factors influence a situation” (p.118). Fook (2005) recommends that practitioners do not discount a variety of interpretations of or potential outcomes in a situation. An assortment of ways to frame and understand the situation should be offered and explored. Suggestions, theories, and meanings should be mutually negotiated between the therapist and the client. Many participants had therapists who struggled with contextuality as it related to fatness. Participants had therapists that focused too much on their individual experience, without acknowledging the systemic barriers around fatness. Others had therapists who focused too much on the systemic, and didn’t provide individual tools or coping skills. Jo expressed their frustration around this:

I need you to help me process and work through this stuff. I've had therapists say, 'That's not your shit. You can't process it. You have to let go of it and move on.' I'm like, cool, except that I have to exist with all this shit thrown at me all the time. How the fuck do I do that?

Ella explained how an individualistic focus impacted her:

I feel like with therapists, especially like if they're coming from like an individual psychology background, like they may be looking at problems as like, this is an individual problem. And maybe like if you're doing CBT, like there's a cognitive distortion or you know what I'm saying? ... So, I think they look a lot at the individual, which is valid. But I think as well, nothing in someone's life is just happening at the level of an individual. And so, if your perspective is that like it's very sad that people were mean to you about what you looked like...but you can't connect that as a mental health professional with like political dimensions of sizeism, looksism, fatphobia, then how

supportive can you be if like, your sort of fundamental perspective on size is negative? So to understand these things from a political perspective and from an equity perspective, and also to understand how they intersect with other dimensions of experience and social location...I think that to be a good therapist, I think you do have to have some understanding of politics. I think that you can't look at people's experiences in a vacuum. You can't look at it as, well, this is just unfortunate that it happened to you. Everything has a structural component. You may not be able to change the structure around the person. But I think that one of the things that has helped me enormously in coming to terms with all of the things that have happened in my life, both positive and negative, has been to understand how they fit into a political framework and how they fit into specifically dimensions such as gender, sexuality, class, race, ability, all of those things, looking from a critical perspective...If you don't bring those things together I don't think you're doing a service to your clients because it's still very mystifying to have, it seems like a very isolating thing. Like, 'Oh well. This is just a misfortune that befell you,' which it is. And also, different kinds of things in society have enabled this misfortune and enable all kinds of other misfortunes. If we only look at it from the individual perspective, we're not going to be able to change it, we're not going to be able to do anything about it.

Aliya sought a balance between individual and structural understandings, and wished her therapist could bring the structural in more:

I think a balance of both would be really useful, because we are all unique people.

Individual set of factors for everyone. But I also think that being able to be like, 'Yeah, that particular complex structure in society really fucks with your life, huh?' Yeah, yeah

it does! I think it's balanced more towards individual and micro...but I could get down with a little bit of understanding of like, 'Wow this system and this system are coming together in a really difficult way for you right now.'

Ruby had a therapist who was able to connect individual and structural. Ruby's therapist shifted individual blame to structural barriers, but also worked on tools and plans at an individual level:

I think she's really been good at taking the center away from my body and putting it on the worlds around me instead, which I think is really important, because I'm not focused on my body as much anymore. It's just how the world is fucked up and structured wrong. And it's on them, fucking TTC...and you know what? Now the more I think of it, that's what she's done. She's really flipped every conversation where I felt insecure or angry or scared to that, to it being what are the tools, let's make a plan. Like 'What do you wish would happen?' 'What's stopping you?' ... Yeah, it's very systematic, the stuff that she's thinking about, and it deflects it from being my fault...The main thing we've been working on is, how do I exist in a fat body?

Conclusion

Dominelli (2002) highlights that emancipatory practitioners can achieve anti-oppressive practice by "focusing on the specifics of a situation in a holistic manner and mediating between its personal and structural components" (p. 85). This should be a goal for all practitioners who are approaching fatness with clients, as many participants did not feel they were getting holistic or well-rounded care. Dominelli (2002) argues that all practitioners need to consider the specific merits of a particular care methods, provide holistic service that starts where the clients are at and works toward growth from there, and facilitate the decision-making capacities of clients in contributing to their empowerment (p. 143). Many participants demonstrated that their

practitioners were not approaching practice in this way, at least not when the situation involved fatness. Education, professional development, and changes to how practitioners approach issues of body size are imperative to fostering positive and empowering therapeutic relationships with fat clients.

CHAPTER EIGHT: DISCUSSION AND CONCLUSION

Navigating a world where neoliberal, eugenic, medical, psychiatric, and body discourses make fat people hypervisible and invisible at the same time took an extreme toll on participants. This dissertation has demonstrated that fat people experience significant social, cultural, relational, medical, psychiatric, and therapeutic discrimination. Fat people are unable to navigate public space, workplace environments, clothing and grocery shopping, family interactions, dating and romantic relationships without getting negative feedback about their body. Fat people are also unable to pursue physical and mental wellness without medical, psychiatric, and mental health practitioners focusing on their weight as the cause of all possible ills.

“It is not our bodies, *per se*, that are invisible; *it is our needs, our individualities, our identities as legitimate social citizens*, that are ignored or disregarded” (Owen, 2008, p. 121).

Participants reacted to the combination of hostility and disregard by policing themselves, disconnecting from their bodies, and engaging in avoidant behaviours. Participants went on diets, over exercised, developed eating disorders, worried about what they wore out in public, monitored their breath, their smell, their sweatiness. Participants tried to ignore their bodies or develop other facets of identity that would hopefully compensate for their bodies. Participants tried to minimize being out in public space, they shopped online, they took Ubers, they got food and groceries delivered. They visited their families less, some of them avoided dating.

Participants put off discussing health issues with their doctors, even if something was causing them severe pain or discomfort. Participants avoided seeking therapists. When participants did work with therapists, they reframed body discussions to be about something else, or avoided discussing their body entirely.

The discrimination, marginalization, aggressions, and microaggressions participants experienced were exacerbated by intersecting experiences of race, sexuality, age, class, ability, and other aspects of social location. In particular, racialized participants had to work especially hard to access care, resources, and opportunities. Participants also experienced stereotypes around their sexuality, with the assumption being that they were queer because their body limited romantic heterosexual opportunities. Participants who had children discussed that prenatal and postnatal medical care was particularly oppressive toward fat bodies. Participants experienced abuse because of their size in familial and romantic relationships. Many participants spoke about the ongoing trauma of living as a fat person and experienced relentless anxiety over existing in a fat body. Participants consistently calculated and projected what other people's reactions to their body might be. They put an enormous amount of mental labour into working to mediate or minimize their fatness.

Through claiming fatness as a political identity, participants found some relief from the fatphobic pressures of their daily lives. Most participants emphasized the importance of language, choosing to reclaim the word "fat". Participants were able to find supportive communities and friend groups where people didn't judge them for their size and understood the toll that fatphobia can take. Participants started reading fat literature, accessing fat resources, finding or making cute clothes, creating fat art, performing, swimming, and engaging in other embodied movement. Though fat activist communities also struggle with internalizing and reproducing neoliberal ideals and gentrifying in ways that excludes fat people that are more marginalized, most participants still emphasized the positive impact that engaging with fat politics and fat communities had had on their lives.

Therapeutic practitioners need to understand the complexities of communication and culture that come to bear on the therapeutic relationship. Participants' histories of size-based discrimination and the ensuing anxiety, self-policing, disembodiment, and avoidance impacted and shaped their therapeutic relationships. Therapists need to consider these experiences in light of how fat issues are widely approached in therapy. Participants' stories demonstrated that therapists are not immune to carrying out oppressive acts. Fatphobic acts are often carried out within social service or health care agencies that often view social problems narrowly and "define them in terms of personal deficiencies, dysfunctional families, and inferior cultures", but they also manifest in the private practice space (Mullaly, 2002, p. 93). "Obesity" is seen as a hindrance to societal advancement. Therapists are expected to treat and reform their clients, and when it comes to fatness there are specific dominant understandings about the ways in which this is to be carried out. "As social workers, we must remember our history and be very suspicious of arguments that rely on the public good to justify the need for individual change" (Friedman, 2012, p. 10). It is important for therapists, and the clients and communities that they work with to understand that fatness is not just a body size, it is linked to social inequality (Baines, 2011). Therapists need to understand size-based structural and attitudinal barriers, rather than focusing on a perceived link between body size and mental wellness. Therapists need to be educated about fat issues and ways to practice that are gentle and acknowledging of people's bodies and experiences.

Recommendations for Practice

"Fat people...do not want tolerance, and do not require fixing, because they are not broken. Fat people do not need pity..." (Friedman, 2012, p. 58). It is imperative that therapists resist upholding dominant discourses by using therapy as an instrument of power. Foote & Frank

(1999) suggest that therapists can work towards therapy being a modality of resistance and a means to heal “the wounds caused by the violences of power” (p. 176). In the spirit of creating a space where clients can resist dominant narratives about “obesity” and work on healing the wounds caused by society’s violences towards fatness, I make the following recommendations for practice, informed by my participants’ experiences and suggestions:

1. Recognize fatphobia as a form of stigma that impacts clients’ lives.
2. Be reflexive around how your own body experiences may impact how you are dealing with fat clients.
3. Do not assume that fat clients are in therapy to talk about their weight, conflate mental health and body size, or prescribe weight loss to improve mental health.
4. Educate yourself about fatness through ongoing professional development.
5. Make your office space accessible to people of all sizes.
6. Have body positive or body neutral signifiers around and in your office.
7. Understand that recommendations made around diet and exercise to improve mental health are going to have extra baggage for fat clients.
8. Find a variety of fat resources to have on hand, from fat liberation to HAES. Listen to your fat clients and think carefully about what resources might resonate most with them.
9. Have the knowledge and willingness to work through internalized fatphobia with clients.
10. Be well versed in individual and structural factors. Approach fat issues with a focus on both micro and macro experiences.

Future Directions for Research

I sought to privilege client voices in this dissertation, but an exploration of therapeutic practitioners will help further fill out understandings around how the body comes into the

therapeutic space and how “body work” is undertaken. Conducting interviews or focus groups with therapists could provide an understanding about how therapists bring their own bodies into their practice and engage in body discussions with clients. This could be critical research for shaping fat activist and anti-oppressive educational or professional development initiatives for therapists and therapy students.

It would also be illuminating to interview fat therapists specifically. Therapists are not only on the treatment and disciplinary side of “obesity” issues, we live in fat bodies as well. My fatness has impacted both staff and client relations and I am interested in exploring the ways that fat therapists’ bodies impact their practice. It would be fruitful to explore how fat therapists experience navigating wider health care and social service agency contexts, as well as individual interactions with clients. Interviews could explore the way fat social workers see themselves being taken up (or not) as “professionals”, when fat bodies are associated with traits that are counter to what are considered to be professional traits. I would like to understand how fat practitioners experience staff relationships in workplaces that are dominated by discourses around preventing obesity and promoting health. I would also be interested to know if fat practitioners experience thin clients giving them feedback about their body, and how they navigate those moments.

Conclusion

“Resistance is no end state where one can be; rather, it is a perpetual process of arrival” (Foote & Frank, 1999, p. 179). Fat activists, fat scholars, and anti-oppressive practitioners are continually working to broaden understandings of fatness and to resist the micro and macro oppressions that surround bodies. Therapists need to engage in ongoing work to incorporate fat politics and body knowledges into their practice. Therapists should arrive at body discussions with fat clients ready

to meet them where they are at and actively listen. Therapists need to validate and empathize with client experiences, and provide strategies and resources that encourage resistance, fat acceptance, and fat liberation.

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APPENDIX A: RECRUITMENT POSTER

HAS YOUR THERAPIST EVER BROUGHT UP YOUR WEIGHT?

I am seeking participants over 18 who live in the
Greater Toronto Area (GTA) for an in-person interview.

You are invited to share your experiences
of weight discrimination during therapy or while
trying to access mental health or social services.

For more information contact:

Sam Abel, samabel.research@gmail.com

This research has been approved by
the Office of Research Ethics at York University.

APPENDIX B: CONSENT FORM

Informed Consent Form

Date:

Study Name: "Let's talk about your weight": How fatphobia manifests in therapy

Researcher name: Samantha Abel, Principal Investigator

Contact Info: samabel.research@gmail.com

Program: Communication and Culture, Doctoral Study, York University

Purpose of the Research:

This research explores the experiences of people who have discussed their weight and body size in therapy. Primary research on weight and social work does not exist and literature on it is extremely rare. I am advocating for weight stigma to be something that is critically considered within the social work field.

This research uses visual data and narrative inquiry to understand participants' experiences. Research findings will be discussed in the researcher's PhD dissertation.

What You Will Be Asked to Do in the Research:

You will be asked to bring in 1-3 objects or images that you feel are representative of your cultural experiences in your body and to discuss these images with the researcher. You will also be asked questions about your experiences with social workers, therapists, and social service providers.

The interview will take approximately 90-120 minutes and you will be provided with a \$20 Tim Horton's card to thank you for your participation.

Risks and Discomforts:

Recalling and discussing experiences of discrimination and marginalization might be uncomfortable, difficult, or upsetting for you.

You may choose to skip over any question, temporarily stop, not finish the interview, or withdraw from the study at any point.

You will be provided with a list of free counseling resources and helpline phone numbers should you need further debriefing after the interview.

Benefits of the Research and Benefits to You:

You may experience some catharsis or closure from getting to share and process your experiences in a supportive environment.

You will also be contributing to a body of knowledge that may improve social work education and training in the future.

Voluntary Participation and Withdrawal:

Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer, to stop participating, or to refuse to answer particular questions will not influence the nature of the ongoing relationship you may have with the researcher, or the nature of your relationship with York University either now, or in the future.

If you decide to stop participating, you may withdraw without penalty, financial or otherwise, and you will still receive the promised inducement.

In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible. Should you wish to withdraw after the study, you will have the option to also withdraw your data up until the analysis is complete.

Confidentiality:

Interviews will be audio taped and transcribed. Identifying interview information will not be included in the dissertation, your anonymity will be protected. You will be asked to bring 1-3 objects or images to the interview. These will be used only if you give your consent.

During the study, all electronic data will be stored on a password-protected external hard drive. All hard copy data and consent documents will be scanned and added to the hard drive, and hard copies will be shredded. Audio files of your interview will be safely stored on the password-protected external hard drive. The hard drive will be kept in a locked facility and only the researcher will have access to this information.

Upon completion of the study, the researcher will archive and store audio recordings, transcripts, notes, signed consent forms, and photographs on a password protected USB key. Data will be archived for potential future publications, conference presentations, and educational initiatives. Any future use will continue to protect your anonymity and change or omit identifying details, unless you choose otherwise. The data collected in this research project may also be used – in an anonymized form - by the research in subsequent research investigations exploring similar lines of inquiry. Such projects will still undergo ethics review by the HPRC, our institutional REB. Any secondary use of anonymized data by the research team will be treated with the same degree of confidentiality and anonymity as in the original research project.

Unless you choose otherwise, all information you supply during the research will be held in confidence and unless you specifically indicate your consent, your name will not appear in any report or publication of the research. Identifying details and information will be omitted or changed in the dissertation to maintain confidentiality.

Confidentiality will be provided to the fullest extent possible by law.

Questions About the Research? If you have questions about the research in general or about your role in the study, please feel free to contact me at samabel@yorku.ca or my supervisor, Dr. May Friedman at may.friedman@ryerson.ca and/or 416-979-5000, ext. 2525. You may also contact the Graduate Program in Communication and Culture at comcult@yorku.ca and/or 416 736-5978

This research has received ethics review and approval by the Delegated Ethics Review Committee, which is delegated authority to review research ethics protocols by the Human Participants Review Sub-Committee, York University's Ethics Review Board, and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, Kaneff Tower, York University (telephone 416-736-5914 or e-mail ore@yorku.ca).

Legal Rights and Signatures:

I _____, consent to participate in “Let's talk about your weight’: How fatphobia manifests in therapy” conducted by Samantha Abel. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature and _____

Date _____

Participant

Signature and _____

Date _____

Principal Investigator

Additional consent:

For use of images and objects

I _____ give consent for Samantha Abel to photograph the images or objects I bring to the interview and to use these in the following ways (please check all that apply):

- | | | |
|----------------------------------|------------------------------|-----------------------------|
| In academic articles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| In print, digital and slide form | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| In academic presentations | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| In media | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| In dissertation materials | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

OR

I _____ give consent for Samantha Abel to:

- Use only the following photographs: _____
- Use the photographs if the identifying details are blurred.

OR

I _____ do not consent to my objects or images being photographed.

For audio recording

- I consent to Samantha Abel audio recording my interview
- I do not consent to my interview being recorded

Participant: (name)

Date

APPENDIX D: CRISIS AND COUNSELLING RESOURCES

Crisis and Counselling Resources

Assaulted Women’s Helpline: 416-863-0511; Toll Free 1-866-863-0511 For more than 25 years, the Assaulted Women’s Helpline has served as a free, anonymous and confidential 24-hour telephone and TTY crisis telephone line to **all women in the province of Ontario who have experienced any form of abuse.**

Distress Centre: 416-408-HELP (4357) offers access to emotional support from the safety and security of the closest telephone. Callers can express their thoughts and feelings in confidence. Callers’ issues can include **problems related to domestic violence, social isolation, suicide, addictions, mental and physical health concerns.** The Distress Centre offers emotional support, crisis intervention, suicide prevention and linkage to emergency help when necessary.

Gerstein Centre: (416) 929-5200 provides crisis intervention to adults, living in Toronto who experience **mental health problems.** The service has three aspects: telephone support, community visits and a ten-bed, short-stay residence. All three aspects of the service are accessed through the crisis line.

Toronto Rape Crisis Centre: 416-597-8808 is a grassroots collective working towards a violence-free world by providing anti-oppressive, feminist peer support to survivors of sexual violence through support, education and activism. Callers can be anyone who has been **raped, sexually assaulted or abused, women who have had unwanted sexual touching, incest survivors and friends or family.**

ConnexOntario: offers province-wide information and referral services for those with **mental health or addiction challenges.** You can visit their website at www.connexontario.ca, or you can call the following numbers which operate 24 hours a day, 7 days a week:

WoodGreen: provides free single session counselling on Tuesday and Wednesday evenings from 4:30 to 8:30pm to address a wide range of concerns, such as **anxiety, depression, trouble with anger, difficulties at work or school, relationship issues, parenting concerns** and other issues.
<https://www.woodgreen.org/services/programs/walk-in-counselling/>

What’s Up Walk In: offers free walk-in mental health counselling for children, youth, young adults and their families, and families with infants at 6 different locations across Toronto. Find the closest location to you here: <http://www.whatsupwalkin.ca/service-providers/>

Family Service Toronto: Free counselling every Wednesday at 355 Church Street from 3:30 to 7:30pm.
<https://familyservicetoronto.org/our-services/programs-and-services/walk-in-clinic/>

Sherbourne Health Centre: offers free-of-charge, walk-in, mental health counselling every Tuesday afternoon beginning at 1:00pm. **LGBTQ friendly.** <https://sherbourne.on.ca/mental-health-services/walk-in-counselling/>

APPENDIX E: INTERVIEW GUIDE

INTERVIEW QUESTIONS

Fat Experience

1. Tell me about your relationship with your body.
2. What descriptors do you use for your body? How do these descriptors make you feel?
3. What messages do you receive about your body?
4. Are there particular spaces where you feel you get a lot of feedback about your body (either positive or negative)?

Objects

5. Tell me about the objects that you brought to this interview. Why are they important to you? What made you choose them?
6. Have your feelings about these images/objects remained consistent?

Therapy Experiences

7. Do you feel your body has impacted your ability to access therapy, mental health services, or social services?
8. Do you currently see a social worker, counsellor, or therapist? How frequently do you see them OR when was the last time you saw one?
9. Do you know the credentials of your current or past therapists?
10. How do you feel about the physical space of your therapist's office? Is it accessible for you?
11. Do you feel that your body size has influenced your interactions with your social worker/counsellor/therapist? How?
12. How did your social worker/counsellor/therapist respond to your body? How did that make you feel?
13. Do you discuss your body and weight in counselling sessions? Why or why not?
14. If you do, how do those discussions about your body size and/or weight go? If not well, did you stay with the therapist? Why or why not?
15. Do you feel social work or counselling services meet your needs? In what ways? In what ways do they fall short?
16. Does your therapist take a more structural or individual approach when discussing body topics?
17. What is the best way for a therapist to approach discussions about body size with clients?