Fat Bodies in Space: Explorations of an Alternate Narrative

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In the School of Social Work

We acknowledge with respect the Lekwungen peoples on whose traditional territory the university stands and the Songhees, Esquimalt and W̱SÁNEĆ peoples whose historical relationships with the land continue to this day.

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Abstract

For far too long ‘obesity’ and healthcare have been inextricably linked, both forming and maintaining distinct narratives responsible for the “fear of fat” North American societies have embraced. Largely unrecognized, fatphobia now permeates individual and social consciousness and creates considerable harm broadly and within healthcare practice and policy. The following study seeks to unsettle the pathologization and binary views of weight and bodies to contribute toa building of a more socially just, intersectional system of care. *Fat Bodies in Space* is a qualitative study situated on the unceded lək̓ʷəŋən territories and grounded in critical race, queer and decolonial perspectives. The disproportionate impacts of fatphobia in Canadian healthcare are discussed through the stories of five self-described fat individuals navigating their health in Victoria, British Columbia. Storywork, narrative and autoethnographic methods were part of the collection and analysis processes. Findings suggest a longstanding relationship between systemicinequities, social discourse and the treatment of fat individuals within health care systems.

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Terminology

Some of the key words used in this thesis are:

Fat as a term and descriptor is used throughout this paper and preferred by fat studies scholarsand community members as way to depart from the pathologizing or medicalizing language of‘obese’, over-weight, etc.

Fat Consciousness stands in contrast to other notions of weight consciousness, where one’s journey to the perfect weight supposedly occurs through a process of mindful self-love. Fat consciousness in this regard, references the ongoing self-conscious discovery or awareness ofone’s fatness, external fat stigma and decision-making process around that discovery[1]

Anti-Fat Stigma/Weight Stigma/Weight Bias all refer to social stereotypes, misconceptions and perceived ‘truths’ about fat bodies. These social stereotypes and misconceptions include beliefs that fat people are lazy, awkward, sloppy, non-compliant, unintelligent, unsuccessful andlacking self-discipline or self-control.

Anti-fatness/Fatphobia develops through these perceptions and is demonstrated through fear,aversion, hatred or repulsion towards the fat body.

Commodification in this context refers to the ways in which public services and people are being transformed into for-profit enterprises. In healthcare, this model serves capitalist and corporate interest, positions physicians as merely service providers and forces patients into aconsumer role (Lown, 2007).

Decolonization (Anti-Colonial): Of colonial nations, Patrick Wolfe (2006) said “invasion is a structure not an event” (p. 111). If colonialism refers to the practice of domination, settler invasion, occupancy and economic exploitation, decolonial work is the undoing. First coined in the “1930s to describe former colonies that achieved self-governance… decolonial work seeks tochallenge white supremacy, nationalistic histories and ‘truth’” (O’Dowd & Heckenberg, 2020, p.7).

Pathologize/Pathologization: To treat a physical or behavioral condition/feature as though itwere a medical condition. “To view as medically or psychologically abnormal” (Merriam- Webster, 2020, para. 1).

Weight discrimination develops from weight bias and stigma as personal biases and social stereotypes about fatness are enacted on fat people. Discriminatory practices and unfair treatmentare the outcome of weight discrimination as fat people experience weight related discrimination in employment opportunities, health care, and through day-to-day barriers (Obesity Canada, 2020).

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[1] At the time of writing, no current working definition of ‘fat consciousness’ was located. This definition as its usedhere was developed over the process of this thesis work and does not wish to disregard previous understandings or definitions of the term should they have been overlooked.

Acknowledgments

I wish to acknowledge with respect Indigenous Peoples, past and present as the original inhabitants and caretakers of these lands called Canada. I especially wish to acknowledge the W̱SÁNEĆ, Lək̓ʷəŋən and Esquimalt Peoples, on whose land this research was conducted and on which the University of Victoria stands. I center this thesis work with this acknowledgment andwith respect to all those who have come before me to create this path.

In further respect, I wish to acknowledge that Black people, refugees, asylum seekers, and many others on these territories and in Canada are not settlers. Black lives present on these lands do notindicate acceptance of or a hand in the colonial project. Invisiblizing Black communities and other communities of color within acknowledgment of land conflates all non-Indigenous bodiesinto "settler" space. This is an act of invisibilization, disappearing the embodied histories of enslavement, forced migration, violence and dehumanization.

Decolonial work decenters us all, especially those who are continued beneficiaries of the colonialproject. Decentering the dominant and 'normative', dismantling white supremacy and systemic racism and inequity, this is the work of all who live, learn and play on unceded lands. May this learning, work and visibility continue.

Dedication

To my supervisor and committee members: Your encouragement and support made this project possible. Thank you, not only for your guidance but for being open and willing to be part of this exploration.

To my participants: You believed in this project and helped me to stay the course, offering not only your stories, but your hearts. I will be forever grateful for each of you and your offerings ofvulnerability, strength and truth.

To the individuals who helped get me here: So many offered support and encouragement, severalwalked the path with me, and some taught me the hard lessons. To all of you, I won't forget your contributions to this journey, that you believed in me and taught me to believe too.

To my partner: This, in so many ways, is yours too. I wouldn't be where I am today unless you held a mirror up so many years ago and demanded I look. I am so thankful that you saw me andhelped me see too.

To the fat authors, activists and media influencers and every fat body that has done or is trying todo this work so that I can too, thank you. You were with me when it was the loneliest with your ability to cut to the heart of my thesis, in 280 characters or less. The criticism indicates that new ideas are hard to hear and harder yet to stand behind. But even the earliest 'thinkers' recognized that new ideas come from "standing on the shoulders of giants" (Newton, 1675). You are all *those* giants.

When we speak, we are afraid our words will not be
heard nor welcomed,but when we are silent, we are still
afraid, so it is better to speak.

– Audra Lorde

Chapter One: INTRODUCTION

Existing in the world in a fat body is its own experience, an experience that is not easily described nor openly discussed. Fat bodies are seen as overindulgent, underproductive, a productof their own making (Russel, Cameron, Socha, & McNinch, 2013), so the suffering of such a body is rarely considered from a perspective outside of blame. I recently disclosed to a friend that I felt fatness was its own kind of suffering. I described an often-daily internal torment occurring regardless of, and parallel to, a fat person's own privileges or intentions. Despite personally embracing positive outlooks and the many joys and opportunities I have and continue to have, I suffer. Self-inflicted pain comes when trying to take up less room, painfully contorting in ways that will allow limbs and flesh to fit into chairs, on buses or exam tables. Bearing the bite of a metal as it sinks into corpulent thighs or ribs, trading one form of discomfort to avoid another. A look of recognition or a flash annoyance is better than the comment, name-calling or joke. The space that I take up is always branded on mymind and for some time after, into my skin. When my fingers find that brand, the patterned skin marked by a grate I was pressed against, the imprinted flesh acts as a reminder: Society says I must become smaller to avoid external harm, wrath or stare; to remain unnoticed.

The call comes to schedule a doctor's appointment or regular screening and so begins the build-up of anxiety and anticipation. These emotions grow while contorting in the too-small waiting room chairs while my brain scans for ways to rationalize a health concern and draw attention away from the scale. Neither rationalizing nor contorting provides any relief. Having been here before there is a knowing, or at least an expectation, that I am going to leave this officein tears, without help and without feeling any better. Waiting on the edge of the too-small chair, steeping in shame, my mind is assaulted with the memory of walking into a clinic with a cold and walking out with weight loss advice. The shame of so many of those experiences carries my mind to job interviews where exuberance must outweigh my weight. Each family dinner spent avoiding the ping pong match of self-deprecating diet rhetoric about bodies much smaller than mine. The reality of my fatness further compiles during privileged opportunities to travel: An almost unusable airplane bathroom, seat belts that are too short or nearly too short to fasten, facecloth-size towels and so many weight restrictions.

I do not make these experiences visible to frivolously complain. Nor is my visibility encouragement towards more dieting, body change and weight loss in the fat community or evendiscouragement of these personal and individual choices. This type of narrative and described harms, though seemingly innocuous and silent have been the topic of social and scientific studiesand debates for decades. Scholars suggest a collective picture of the typical fat experience, indicating those “who consider themselves fat no matter what their size, experience unnecessary psychological pain” (Guthman & DuPuis, 2006, p. 433). But why suffer? Why the unnecessary pain? Diets, weight loss medication and bariatric programs are right around the corner, *just* within reach, if you *just try*. Right?

On the contrary, I refuse to accept a binary, one-size-fits-all world made for thin people where bodies must change in order to ‘fit’. I refuse acceptance of a weight-centric medical modelin which ‘healthy size’ is determined by categories developed before the turn of the last century, never meant for personal health evaluation. Fatness does not always indicate disease or ill health (Friedman, 2012). Not all fat people are unhealthy in the same way that achieving thinness does not automatically grant good health. The average weight related conversation turns to comparison, or narrow, personal anecdotes to provide ‘proof’ that, for example, someone who could not get out of bed is healthier because of losing weight. I would counter, that, unfortunately within North America, many people, especially the underserved, are unable to get out of bed for health reasonsunrelated to weight, and ‘obesity’ is getting in the way.

A new wave of fat consciousness has become part of social and political discourse, growing in the fabric of many individuals’ motivations, decisions and actions. Fatness is more than discourse, negative or otherwise. Fatness has many histories and resulting fat stigma has broad reaching, systemic impacts. By focusing on healthcare, this study intends to shift understandings of fatness and fatphobia, further establish the connection between anti-fatness and anti-black racism and contribute to the improvement of systemic inequities fat bodies are facing in Canada. Fatphobia does not just produce discomfort, embarrassment or shame, peopleare dying. Fat people are dying because they are only seen as fat (“Woman uses obituary”, 2018). As activist and scholar Dr. Cat Pausé stated: “Health is one of the few lenses through which we, as a society, are capable of viewing fatness” (2018).

Now is the time to set aside previous notions of ‘obesity’, fatness, dieting, and to work towards a collective understanding that fat alone does not cause or create suffering, nor will the simple absence of fat eliminate it. Honest awareness is necessary in the development of visibility, recognition and acceptance of fat bodies and is essential to the abolishment of systemicweight related stigma. The study, *Fat Bodies in Space* (*FBS)* seeks to demonstrate that when weight or size is pathologized, viewed as an acquired condition rather than a trait, fat stigma becomes undeniable. Stigma hurled at fat bodies without fact is part of daily life for a fat person. Fat people are regularly subjected to discrimination, humiliation, repulsion and even rage, just for being fat (Amlund, 2020; Millman, 1980; Guthman & DuPuis, 2006) despite any evidence of ill health. Oversimplifications about, and opinions on, fatness do not exist merely at home on individual levels of discomfort, disgust or shame. These feelings and beliefs seep into social and structural realms through media, policy and education and have disproportionate and violent impacts on already marginalized andracialized persons.

Binary ways of thinking extend beyond gender. Moving beyond binaries involves askinghow our western world meets those who are deemed “non-normative”? Who and what defines the ‘normative’ and who or what determines a deviation from ‘acceptable normativity’? Just as fatphobia grew from what was classified ‘normal’ or ‘deviant’, so too grew the medical model with its facts, measurements and empirical, scientific evidence. Many scholars now make space in their work for multiple ‘truths’, world views, experiential knowledge and a critical eye towards how knowledge was and is produced. As a result of these growing understandings, it might be suggested that western scientific knowledge creation can no longer consistently claim fact or impartiality.

Situating Research & Reader

Situating Self

When I moved to Victoria, B.C. to pursue my master’s degree, I considered myself ‘healthy’. Though active and able, I was still fat and have been since I was a child. Within the first six months of my move, I badly cut my hand during an incident in the kitchen. What began as an unassuming cooking injury would not heal and spurred a four-year health expedition occurring parallel to my academic and thesis work. It took writing the majority of this document to see I had become indivisible from this document and from the findings of this research. Much of the literature was read in waiting rooms, blood labs and pharmacy parking lots. I make no claims to be fully ‘unbiased’ or to have maintained what might be considered ‘adequate distance’ from the process. Division for the comfort of others or myself is unrealistic. I am wholly part of this work. I am as much this ‘population group’ as my participants were. Realizing this promptedinclusion of my own story which was collected in the same way as the participants stories. Fat acceptance has changed the trajectory of my life, career, personal health and how I choose to receive care. Acceptance has prevented shame from entering the doctor’s office with me, taughtme to advocate for myself, persist in the face of dismissal and fight for the visibility of others.

In addition to my fatness, I identify as Queer/Two Spirit and as a second-generation adoptee of mixed Indigenous and settler ancestry. Though I work, learn and grow on the uncededterritories of the Lkwungen Peoples, I am an uninvited visitor. I was born and spent twenty-five years on the traditional territory of the Haudensaunee and Anishnaabeg, lands recognized by the Upper Canada Treaties and directly adjacent to Haldimand Treaty Territory, site of the Grand River land dispute. The positionality I have and identities I carry inform my ways of being and doing. They have become part of how this thesis work was conceived, perused and documented and how it will go on to inform my own praxis and activisms.

From Objective & Purpose to Intention & Audience

This thesis work began as a way to confront the North American, and in my case Canadian, medical systems on their treatment of, and harms to, fat bodies. At the outset of this thesis work I focused on healthcare visibility and bringing a diversity of fat voices and experiences to the forefront. I saw writing a thesis as a way to push back against dominant notions of normativity or health and to reimagine socially just ways to care for and evaluate the wellness of those existing in fat bodies. This study does not ask the reader to engage with an entirely new idea or something not previously considered. Reaching broadly to various theoriesand topics, *FBS* confronts the readers' ingrained ideas, beliefs and feelings, many of which are long preconceived and unconscious. "Fat" touches everyone in some way, whether it's the experience of living in it or living to avoid it.

Unpacking racial and historical underpinnings of fatness and social systems forces a closer look at human consciousness. Fat or not, an individual's consciousness houses "the stream of experience that appears when we wake up and disappears when we fall into deep sleep" (Gamez, 2014, p. 2). Consciousness is personal awareness, housing understanding, behaviors, problem solving, responsiveness and communication (Gamez, 2014). Despite its importance to the human experience, the subjectivity of consciousness continues to make its value a contested topic. Humans are believed to be motivated by bias, inevitably leading to either the denial that consciousness exists at all or that there is no way to quantify or scientifically study this phenomenon that makes us human (Gamez, 2014). Looking at fatness through the lens of health care, anti-black racism and social inequity allows human consciousness to become more measurable. In considering the ways inner thoughts, bias or beliefs have contributed to the political, social and economic fabric of North American society, the idea that fatphobia can have a systemic effect is not far reaching.

Fat Bodies in Space (FBS) is meant to stand with existing literature on fat acceptance andfatphobia, supporting the turn of critical perspectives into critical systems of care. To create spacefor fat realities, histories, experiences and harms, connections had to be made between the creation of dominant narratives of fatness and the consequences those narratives have on the wellbeing of communities, fat and otherwise. Qualitative methods were used to approach these broad objectives and bridge some of the gaps between divergent communities, theories and fieldsof study. Several local fat community members on Vancouver Island shared their stories and experiences through narrative interview and storytelling modalities. Towards the end of data collection, autoethnographic elements were introduced as a way to further decolonize the research process and build on the importance of consciousness within this topic.

Summary

This first chapter is meant to broadly introduce the reader to fatphobia and fat stigma and begin to consider fat differently within healthcare spaces. In chapter 1, I position myself alongside the research, demonstrate the significance of the topic and briefly introduce the research process. Chapter 2 provides an overview of the examined literature and theoretical perspectives. The methodology for this research is described in Chapter 3 and Chapter 4 entitled ‘Conversations’, guides the reader through each participant’s story, including my own. Chapter 5 discusses analysis process, methods and the development of themes. The 6th chapter concludes this work with a discussion of limitations, areas for future research and application to social workpraxis.

Chapter Two:
LITERATURE REVIEW

Introduction

On the experience of being a fat person in North America, west-coast writer and activist, Lindy West (2017) indicates that "no one is getting it right…from the food industry to the mediato the health policy experts themselves… [she believes] we've created a society that stigmatizes fat people without bothering to help them" (in The Takeaway, 2017, p. 1). As a result, fat phobiaand anti-fat stigma have become nefarious players in the North American "war against obesity" and, subsequently, the war against fat bodies (Friedman, 2015). Rinaldi, Rice, Kotow & Lind (2020) define fatphobia through the lens of intersectionality and affect theory, conceptualizing fatphobia as an affective force or forces that moves through spaces, feelings, attitudes and unconscious beliefs. The word fatphobia from its origins signifies hatred, dislike, or contempt offat, fatness and fat persons. Even without having known its name, fatphobia has become invasiveand resides in most North Americans. *Fat* as a word is not meant to be defined or characterized by this study or review of literature. Fat is not just a number on a scale or category within an outdated index. Fat is a political subject and fat activism can be done by anyone for any reason (Cooper, 2016).

The effects of fatphobic or 'obesity' narratives can be understood and taken up by diverse audiences and sectors, promoting a less fragmented form of knowledge production. As a result, this literature review transformed into a method of research, attuned to the fast, burgeoning pace of fat acceptance, its variety of contributors and intended audiences. Snyder (2019) summarize this vision and its significance within research: "An effective and well-conducted review… creates a firm foundation for advancing knowledge and facilitating theory development… By integrating findings and perspectives from many empirical [areas], [it] can address research questions with a power that no single study has" (p. 334). Thorne (2009) adds to this view on research through the use of interpretive description, which seeks to discover and better understand relationships, patterns within the phenomena. The following chapter draws on many perspectives as a way to connect diverse areas of study, shift narratives and to strongly bolster potentially new ways of thinking about fat. Chapter two is also intended to bring the reader along a similar journey taken by the writer/researcher. It is intended that when readers come to the end of this document, where conclusions are drawn or opportunities for change are suggested, ideas won't be received as 'far-fetched', a form of 'denial' and less space will exist for the question "but isn't fat unhealthy?".

Exploring Non-Binary Thinking

Offering a radical departure from the dominant, Queer Theory introduces shifting narratives and binaries. As a word, queer references "whatever is at odds with the normal, the legitimate, the dominant" (Halperin, 1990, p. 77) and queer movements continue to challenge dominant notions and social practices. Queer advocacy emphasizes the social and cultural construction of every-day life and works to renounce fixed binaries of identity, body, sexuality orotherwise (Halperin, 1995). Within this context, "queer" functions as a verb and queering becomes "the very act of deconstructing or at least questioning the categories and methodologies naturalized within scholarly discourse" (Blackmore, 2011, p. 79). Early uses of the terms queer and Queer Theory were commonly associated with sexuality. However, Queer Theory in a postmodern world strives to disrupt all binary constructions of normativity and deviance (Blackmore, 2011) including settler colonialism and patriarchal systems of oppression (Smith, 2010). Beginning with a queer lens immediately makes space to challenge dominant, binary ideas and create room to understand fatphobia and ‘queer’ as things simultaneously occurring both on and off of bodies.

The construction and effects of fatphobia are both individual and structural and are evidenced by discrimination and exclusion. Social workers and other enablers of social change are in unique positions to “consider the implications of bodies that are perceived [and treated] as deviant based on the basis of size” (Friedman, 2012, p. 54). Fat deviance has been examined outlining contemporary views of fat as surplus flesh (Cooper, 2007), “suggest(ing) a fat body was originally a thin body that now carries unnecessary fleshy baggage” (p. 35). The binary perspective that within all fat bodies exists a thin body waiting to emerge promotes fat deviance in the dominant social and political realms. Health policy regarding fat becomes established uponbinaries responsible for the ‘obesity lens’ and the “obesity epidemic”. The epidemic view claims fatness impacts not only individual health and the health of North American children, but as wellthe environment, economy and each citizen’s pocketbook (Campos, 2004). Fat bodies are cited as being responsible for rising costs of healthcare, chronic disease, premature death, poor pregnancy outcomes (Oglivie & Eggleton, 2016) and even global warming (Russell, Cameron, Sacha & McNinch, 2013). Some statistics claim that ‘obesity’ is the cause of upwards of 1000 deaths per day within North America (Campos, 2004).

When presented with notions of fat acceptance, critics responded consistently from the ‘fat is unhealthy’ paradigm (Friedman, 2012). Outside of academia and fat studies, there has been a lack of space given to fat bodies and fat academics to respond to critics of acceptance. Though some sections of this work may discuss the pathologization of fat bodies, the intention is not to debate, disprove or engage with the "fat is unhealthy" paradigm. Readers of fat acceptance work may be quick to argue that loved ones are dying as a result of 'morbid obesity', to diseases like diabetes and high blood pressure, diseases often overrepresented within Black and Indigenous communities. Sex educator, influencer and activist, Ericka Hart (2020) responds and points to what has been missing: "Black [BIPOC] people are not healthy due to diets; this statement is false. Systemic racism impacts…overall wellbeing and access to food, period…Eat all the carrots in the world but your body still carries ancestral and your own trauma from living as a black person in this country" (Hart, 2020, para. 1). Fatphobia and systemic racism have worked and grown in tandem. To further develop this idea, the following section will discuss anti-black racism in relation to fatness and fatphobia. The intention is to contribute to visibility and awareness around some of the deeply rooted arms of systemic racism and repercussions on BIPOC's (Black, Indigenous, People of Color) bodies, fat and otherwise.

Anti-Black Racism and the Birth of Fatphobia

At present and historically, western medicine and academic research have contributed to the creation and permeation of fatphobia, anti-black and anti-Indigenous racism within society. Grey, or non-academic resources, were crucial for context and in many ways became the pulse of this work, attending to the current nature and rapid growth of fat studies. Critically exploring resources and literature revealed the undeniable indivisibility of anti-blackness and fatphobia.

Given that fat studies and pedagogy is driven by fat-activism, non-academic literature was crucial for context. Community and activist work were in many ways the pulse of this work,attending to the current and rapidly accelerating growth of fat acceptance.

Within *Fat Bodies in Space,* the work of fat, BIPOC and critical race context and analysis provided rich insight into the deeply racialized history and background of fatphobia and fat acceptance. BIPOC are at particular risk of discrimination and harm navigating a fatphobic society and healthcare system (Frohard-Dourlent, Strayed & Saewyc, 2017; Fikkan & Rothblum,2012; Friedman, 2015; Lee & Pausé, 2016; Kersh & Morone, 2002). *Fat Bodies in Space* did not directly engage over-researched, racialized populations, but it was necessary that the literature be distilled to enable closer examination of systemic and racialized underpinnings. This section is critical in connecting the influence white supremacy has had over Black and fat histories and realities and how systemic racism has come to influence systems of care. This section also intends to increase awareness amongst non-BIPOC communities who are implicated and benefiting from a system rooted in white, western knowledge.

Currently, Black and Indigenous Peoples are more often pathologized, more often suffer at the hands of medical professionals and are left out of conversations and developments of policy and guidelines pertaining to their own health and welfare (Disparity in Health, 2020). The COVID-19 pandemic throughout the past year only further highlighted the harm and need for reform. “Rejecting individualism and the pathologizing of black behavior and instead examining the effect of racist policies may allow us to clearly reframe the problem as structural, opening the door for the creation of anti-racist solutions that will help communities stay safe and healthy during the current pandemic and beyond” (Pendleton, 2020, para. 8).

Systemic racism, the ways in which racism impacts racialized individuals at institutional, structural and social levels (Allan & Smylie, 2015), has become a popular 'buzz word' in our news and social media. With criteria confined to the last twelve months, a Google search for systemic racism on September 15th, 2020 produced over sixteen million current articles and the University of Victoria library database produced over seventeen thousand results. The presence of systemic racism, white supremacy and the consequences of these over time have become more visible and present to society at large, most importantly the non-BIPOC population. Black and other non- white voices and experiences are being amplified in newer, larger arenas due to the visibility of violence and a growing culture of awareness around an issue that has existed for generations.

Jagmeet Singh, the leader of the Canadian Federal New Democratic Party, uses his own experiences with systemic racism to articulate the urgency with which we need to address anddismantle white supremacy.

> We're in a moment right now as we all know. There's been people taking to the streets, demanding action on systemic racism. Thousands of people across the world are saying we need to do something about it…We see people marching. And some people thought this wasn't a Canadian issue…but for a lot of racialized people this has been a problem in Canada as well…In this moment, where Indigenous people…black people, [People of Color] are being killed, being brutalized in Canada…We have not seen any action (Singh, 2020).

I refer to systemic racism as a buzz word not because I fail to see the many realities of systemic racism or believe it to be a passing trend. Mainstream discourse often fails to acknowledge or integrate the extent to which systemic racism violently manifested and continuesto manifest. For example, the current recognition that police brutality acts as an arm of systemic racism is an important step forward for change, but this is not a stopping point. Racism and white supremacy permeate the multitude of systems organizing our society from healthcare to education, judicial to legislative and will not be dismantled without addressing each aspect at its foundations (Allan & Smylie, 2015). The violent perpetuation of systemic racism and injustice within criminal justice and other systems is being called out in Canadian and American societies. Sustained change is being demanded now to benefit current and future generations (Turpel-Lafond, 2021; Neustaeter, 2020). When the COVID-19 pandemic impacted social systems around the globe in early 2020, especially the populations with which I support as a social worker, I had to stop and reconsider the importance of doing a thesis at a timethat so much on-the-ground work was needed to be done. However, with rising police brutality, unlawful deaths and a palpable increase in social awareness around systemic racism and it's impacts, it is necessary to make visible the significant and pervasive forms of discrimination and racism that have grown for centuries through white supremacy.

Fatness, anti-fatness and fatphobia intersect with the current reality of racism and discrimination in Canada and the U.S.A, not because the fat body is to be seen as oppressed or to be compared to the experiences of BIPOC communities, but because they are indivisible: Anti- fatness was born and raised alongside and as a result of anti-blackness (Turpel La-Fond, 2021; Kafer, 2013; Strings, 2019). Anti-blackness and fatphobia are inextricably linked and fatphobia cannot be discussed without centering Black realities. Sabrina Strings (2019), author of *Fearing the Black Body: The Racial Origins of Fat Phobia*, critically examines historical perspectives and argues much of fat phobic advancement in North America came with “the transatlantic slave trade and the spread of Protestantism” (p. 6). Strings (2019) posits that racial scientific rhetoric about slavery “linked fatness to greedy Africans” (p. 6), and religiosity, which saw fatness and overeating as ungodly and immoral. Strings (2019) asserts that the circulation of anti-fat bias through racist and religious ideologies has occurred for over two centuries. These ideologies cultivated the image of 'the fat, black woman', created by racist and religious beliefs to "both degrade black women and discipline white women" (Strings, 2019, p. 6). This discipline was and is seen via strict standards of bodyshape and size, beauty and preferred mannerisms.

It was during the 1700's that racial classification was established by early white scientistswho articulated in their findings a newly constructed identity *for* black Africans (Strings, 2019). The paternalistic and defamatory construction of identity included claims of overindulgence, corpulence and 'plumpness', each of which became, in this perspective, 'defining characteristic' of the black body. For the white, European, scientific community, these characteristics evidencedlow wit and an idle, lazy lifestyle (Strings, 2019). It is worth noting that although racial theory and race sciences persisted changing with each iteration, notions of gluttony, immorality, and fleshiness would continue to be tied to skin color. Despite shifts over time, the lengthy history of racial theories has "linked fatness to blackness in the European imagination. And…also linkedthinness to whiteness" (Strings, 2019, p. 98). In this way, fatphobia originates in and remains linked to racism. Parsing out forms of anti-black racism and systemic harms across history, especially in healthcare, is a critical component of identifying the roots of contemporary discrimination and inequity.

Alternative narratives and redeveloped approaches to healthcare are necessary, however continuing to do so through a generalized, white, western lens increases the burden on Black andother communities who have been pushed to the margins of society. When it comes to the health care connection, one need not look further than H1N1 or

COVID-19 fatality studies and the responses to those pandemics past and present. These health care crises have demonstrated socialand racial disparities correlative to higher rates of hospitalizations, fatalities and lowered access to care (Crouse-Quinn, Kumar, Freimuth, Musa, Casteneda-Angarita & Kidwell, 2011; Mays & Newman, 2020). On top of racial disparity, risk is suggested to increase when an individual is identified as ‘obese’, and ‘obesity’ was indicated as a risk factor for both H1N1 and COVID-19 (Crouse-Quinn et al., 2011; Rosencrans, 2020).

What was already known about the challenges faced by fat bodies of color accessing healthcare coupled with information collected from previous epidemics encouraged early criticism regarding fatphobic recommendations. Front line workers and activists took to social media and news outlets to emphasize often-undervalued findings and limitations. “Smaller bodied people systematically receive antiviral treatment earlier than larger bodied people. [And]controlling for this difference eliminates [the] impact of obesity on H1N1 fatality” (Rosencrans, 2020, para. 1). This information suggests that the fatalness of ‘obesity’ in this case comes from bias, not biology. Throughout the COVID-19 pandemic, Robert Rosencrans (2020), a medical student and activist from the U.S.A., has delivered a digital fatphobia awareness campaign, demonstrating connections between fat activism and current political climates. Rosencrans’ (2020) stance is that “weaponized fatphobia powerfully masks structural racism” (Rosencrans, 2020), a critique offered following the release of COVID-19 race-specific statistics in the USA. Studies found that Hispanic children are eight times as likely as white children to be hospitalizedfor COVID-19, while Black children were five times as likely (Blackstock, 2020).

The rationale that higher ‘obesity’ rates in these communities’ act as a possible causal factor (Schwartz, 2020) points to both the roots and modern-day manifestations of systemic racism and fatphobia. The same type of thinking has weaponized fatphobia within health and social systems allowing it to become a catalyst, in many ways, to social regulation. Racialization, fatness and fatphobia as social control positions citizens to regulate and impart control upon one another, seemingly without government influence. The ever-growing realm of diet culture within North American society and its relevance to the topic of fatphobia provides an opportunity to build on notions of regulation.

What do Diet Culture, Colonialism and Foucault have in Common?

In order to talk about diet culture, there must first be deeper discussion into how western culture came to be fixated for generations on bodies and dieting. To capture less visible, yet arguably more insidious, ties between social regulation and fatphobia this section will draw upon Decolonial and Foucauldian perspectives.

Within Canada and many colonized nations, early policies upholding social regulation or control later merged with cultural assimilation (Smylie & Allan, 2015; Turpel-Lafond, 2021). Assimilation was a tactic, that for Indigenous peoples globally, is and has been tantamount to cultural and physical genocide (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). Assimilation and supremacy have a long history across North America, in one way beginning with the violent intervention of the colonial project. Colonization is responsible for historic and contemporary discourse presenting Indigenous, racialized or 'non-normative' bodies as 'deviant', positioning them at the margins of what has been determined to be dominant society (Harjunen, 2017; Kafer, 2013). Particular ideas and assumptions deemed 'truth' by settler governments about Indigenous peoples were responsible for a series of assimilative policies, practices, and institutional structures developed to ‘address’ Indigenous deviance (what was called the ‘Indian problem by Duncan Scott Campbell in 1910) over time (Leeuw, Greenwood & Cameron, 2010). Lloyd & Wolfe (2016) suggest there exists a “fundamental continuity between the historical developmentof European settler colonialism and the present-day development of the neoliberal world order” (p. 111). It could be said that both colonialism and then neoliberalism was employed as early means to regulate and manage growing or surplus populations and to integrate or eliminate the deviant, non-normative ‘other’. The goal and benefit of regulation or elimination allowed an establishment of difference and superiority and the development of a means with which to colonize both land and bodies (Smith, 2011).

In many ways, colonialism is defined and marked by points in history but remains situated in the past, unable to acknowledge ongoing and contemporary manifestations of settler colonialism (Barker, 2009). Conversations attempting to unpack, understand or undo colonialism often hold to one-dimensional, point-in-time definitions, citing a nation’s control, be it politically, culturally or economically, over another (Buckman, 1995). Liner and western definitions positions Indigenous Peoples at a single point in time, cast as historical artifacts without space in the present or future. Western colonial narratives and their wake of erasure also overlook internal dimensions of colonization, the ingrained nature of subordination and domination housed within the colonialproject and how those come to play out on generations of human lives and spirits. Subordinationthrough colonial efforts, historically and currently serves only the interests of the dominant group, “fortifying its position and eroding choice for non-elites through force, authority, influence, and dominance” (Buckman, 1995, p. 89). From this view, the colonizer or dominant group (non-Indigenous, ‘normative’ or assimilated) has a clear pathway to power and influence over ‘truth’, and acceptable conduct and structure for society. This leads to dominant groups or ‘elites’ who take control of the narrative and inevitably control the developing of policy, culture, religion, economy, education, and legal and governing bodies, such as medical associations (Buckman, 1995).

Fueled by racial inequity and reinforced by propaganda and social policy, these dominantand long-engrained colonial tactics and ideologies have come to dictate North American behavior, standards or conduct (Driskill, et al., 2011). Division through classification (race, economic class, physicality) promotes physical and psychic (mental/emotional distress or impact) violence towards the non-elite ‘other’ (Said, 1978). Connecting the colonial project, resulting ideologies and instruments of division, bell hooks (1992) furthered that control over the image-making processesis a vital part of systems of dominance. ‘Obesity’ discourse as a means of ‘image-making’ has become part of these processes taken up within these systems of dominance (Guthman, Oliver, 2006). These concepts would suggest, as a tool, ‘obesity’ discourse also attempts to erase fatness in time and space by pushing fat bodies to the periphery of history. This way the existence of fatness is only understood or acceptable within a particular era or time, like the Renaissance, which has been deemed appropriate and part of white, western and European culture. Modern framing of fatness demands changes and weight-loss, forcing fat bodies into a constant state of temporariness and flux. The more dominant anti-fat discourse only makes space for a fat body that *became* fat, and one who, in the present, is working towards a thin or non-fat future (Rinaldi, Rice, Kotow & Lind, 2020).

Dinner in the Panopticon

Does this version of image-making really apply to fat? And do structures and systems *really* have anything to do with fatness and fatphobia? It can hardly be argued that, in contemporary life and conduct there isn't a moral preoccupation with 'watching what we eat' (Trainer, Wutich & Brewis, 2017, p. 501). And it *has* been argued that 'obesity' discourse has the ability to both produce and reflect neoliberal governmentality (Guthman, 2009; Guthman & DePuis, 2006; Afful & Ricciardelli, 2015) which Foucault (1978) defines as the conduct of conduct. Dean (1999) clarifies further indicating governmentality to be "the principles by which we govern ourselves as opposed to how we are externally governed" (Guthman, 2009, p. 114). An example of governing at the internal level is likened to that preoccupation with diet, food and'what we eat'. Taking from Foucault's (1975) view on bodies, Trainer, Wutich and Brewis (2017) suggest "perhaps, at this point, we all eat in a panopticon" (p. 510). That is, where the experience of being watched over by higher powers (the "obesity" epidemic, healthcare, government policy, diet culture, advertising, social media, family and friends) produces the effect and feeling of being surveilled and the side effect of governing ourselves and those aroundus. Self-governance, especially for fat bodies, is both internal and external. A person's belief systems, family history, experiences all contribute to internal governance. Whereas, externally, the physical body is a visible social signifier for personal consumption choices (Trainer, Wutich& Brewis, 2017). The personal discovery of this type of governance is described by Harjunen (2017) in personal accounts:

> At the age of seven I started to learn that my body was a problem… That it was my responsibility to do something about it… Indeed, the governing of the body and learning about body norms takes place in everyday settings and everyday life. I did not comprehend… My body was now under surveillance, my weight was monitored,

I learntthe art of self-regulation and self-governing (p. 2).

Self-regulating and governing in this way can look like food choices a person makes in certain groups settings that they wouldn't have made in others or when alone (Gutting, 2005; Trainer, Wutich & Brewis, 2017). Ordering salad over steak.Refusing dessert. Not eating in public. In many cases, those restrictions in public lead to private 'indulgence', avoiding perceivable judgmental or moralizing looks and remarks. In my experience, I have witnessed 7/11's as sites of food moralizing in action where cars idle or park and mostly solo drivers quickly consumehot taquitos or bag of chips before returning home or to the office.

This way of thinking about control and regulation grew from Foucault's (1975) modern modes of disciplinary control. The purpose of disciplinary control, Foucault (1975) indicated, was the production of the docile body, or "bodies that not only do what we want but do it in precisely the way we want" (in Gutting, 2005, p. 82). Hierarchal observation as one mode is founded in the reality that, once under observation, people will adjust their behavior. Foucault (1975) looked to architecture to develop this idea, noting the structural formation of fortresses, palaces, and eventually prisons, all which were designed two-fold, to look down upon subjects while displaying personal status, dominance, and majestry. It was within the prison system that Foucault encountered maximum social control via Jeremy Bentham's Panopticon (Bentham & Božovič, 1995; Miller & Miller, 1987), a principle that has come to pervade contemporary spaces (Gutting, 2005). This principle is best understoodby considering the prison watch tower, with its multi-directional view and armed guards. The principle or mode of control implemented here is not the guards and guns themselves, but the element of observation and the prisoners' inability to predict when and where they might fall under the guards' gaze (Bentham & Božovič, 1995; Miller & Miller, 1987; Gutting, 2005; Trainer, Wutich & Brewis, 2017).

Other modes work through normalization, standardization and documentation. Citizens are judged, not necessarily by their skills, intrinsic worth or value, but through the way their actions rank them relative to others (Gutting, 2005) never considering the moving bar or who even has access to the arena. Fatness and fatphobia become pervasive forms of control in this cycle because they serve and compliment the unequitable system and social order (Friedman, 2012). School, employment, personal and physical gains all offer a never-ending, ever-changing ladder of possible achievements. Where one accomplishment is achieved, many more exist at higher and higher levels, and so the cycle persists by both producing norms and setting controls (Guthman & DuPuis, 2006; Guthman, 2009). With modern power structures invisibilized, power is revealed through the attainment of status or documents which can be traded as knowledge and used to establish further power and status (Gutting, 2005). Thedaily pursuit of the 'North American dream' and the ladder to power and social acceptance becomes focused on moving targets as determined by dominant discourses and unequitable systems. These normalizing powers or modes of discipline center, in a western frame, social integration and participation. At the core it becomes those at the top who stand to gain.

Normalizing, disciplining, gathering knowledge, documents, power and status. It is all intended to maintain a class-based society where individuals are told if they just work hard enough, and integrate, they too can climb the ladder (Gutting, 2005). But, if everyone arrives at the top, who is responsible forserving dinner in the panopticon?

And What About Diet Culture?

One of the most effective integrational tools for fat bodies in a modern society of norms and ladder climbing is consumer capitalism (Yingling, 2016). Though posed as an economic and political theory,consumer capitalism drives economies through reliance on consumers continued participation inthe purchasing market (Shrader, 2019). The system of consumer capitalism and its reliance on individual spending continues to be uncovered and critiqued globally, going to manipulative and insidious lengths to maintain sales (Shrader, 2019). All bodies are repeatedly victimized or monetized by capitalist endorsements of 'the ideal body', manifesting largely through advertising, pharmaceutical manufacturing and distribution, wellness and alternative medicine, education systems and policy. There arguably exists a long history of taking extreme action towards "idealism" and weight loss, that began as early as 1028 with William the Conqueror whodocumented an all-liquid diet to combat weight gain (Wdowik, 2017). Consuming alcohol over food was a 'diet' attributed to an Italian nobleman in 1558 followed by pharmacologically inducing sleep to avoid opportunities to consume food and swallowing tapeworm eggs that, oncehatched, would help expend stomach contents (Wdowik, 2017, Zapata, 2016). Tapeworm diets *did* manage to make their way into modern-day clinics and online forums, despite disputation, absence of evidence and failure to receive approval from drug administrations (Zapata, 2016).

In this current age of disordered eating, it is evident that, "on one hand, buying and eating (being good consumers) is encouraged…[but] on the other, deservingness is performed by being slim, such that the good subject buys more and weighs less" (Guthman, 2009, p. 114). Campos (2004) identifies bulimia as the ideal metaphor for "the excess of consumer capitalism” (p. 234), drawing from the words of mid-century marketing analyst, Victor Lebow (1955), “our… economy demands that we make consumption a way of life, that we convert the buying and the use of goods into rituals, that we seek our spiritual satisfaction in consumption…We need things consumed, burned up, worn out, replaced, and discarded at an ever-increasing rate” (p. 191).

Campos (2004) connects this notion to the binge-purge ritual of bulimia: consumer capitalism’s “endless buffet” (p. 234) and the North American pursuit of the ‘ideal’. The pursuit of the ‘ideal’ and ‘ideal body’ has been centered so much within North American society that eating disorders have the highest mortality rate of any mental illness (National Initiative for Eating Disorders, 2020). Suicide has become the second leading cause of death for those suffering frommental illness, and additionally impacts 25-35% of those living with eating disorders (National Initiative for Eating Disorders, 2020). The way disordered or ‘troubled eating’ is understood or defined “often relies not on eating practices but on the types of bodies that are doing the consuming” (Trainer, Wutich & Brewis, 2017). Again, there is a centering of thinness and fatness and the meanings pre-ascribed to size. In this sense, fatness has the power to overshadowidentity and marginalization (and in this case mental health challenges) and increases both personal and societal attempts to regulate and discipline the fat, ‘deviant’ body (Lupton, 2013).

Bringing it Back to (Health)Care

Regulation of deviant bodies has remained integral across time and place, though globally there was a tangible shift, both socially and governmentally, towards individualism and self-determination. Tanana Athabascan scholar, Dian Million (2013) regards these shifts as perceived “decolonization’s”, but more specifically, as moves towards the rise of the neoliberal world-scape. For many, including BIPOC, who were not brought into the early liberal fold, these shifts “ensconce[ed] them in social and economic conditions that [provided] no political recourse [for people to] actually take care of themselves” (Million, 2015). ‘No recourse’ shows up, in one way, through insurance privatization and health service fees. There is a failure here to consider intersecting systemic barriers to coverage like cost, access and inevitable exclusion (Campos, 2004). Further, there is failure to consider the path taken to definitions of ‘health’ and whose bodies and perspectives these standards were based on.

Constructing the BMI

Research seeking connections between fatness and conditions often ascribed to fatness including hypertension, diabetes or cardiovascular disease, found only a 9% correlation betweena higher BMI and negative health impacts (Burgard, 2009). Why, then, is fatness responsible for what is being labelled a public health epidemic (Lilley, 2019)? Or called an “astronomical [and] severe public health crisis” (Griffin, n.d., para. 2)? Attempts to find, examine andbuild correlations between health and weight often lean into long-used tools and scales of measurement such as the Body Mass Index (BMI). An individual’s BMI is derived from their height, sex and weight and used to classify personal health and is commonly implemented by medical professionals (Campos, 2004; Eknoyan, 2006). BMI is seen as trusted, simple, reliable and transparent; however, ignoresoverall context, individual difference, and the lens with which it was originally created. BMI is attributed to Adolphe Quetelet, a white, Belgian astronomer and theorist who, in the mid 1800’s, developed the Quetelet Index (QI), later becoming the BMI (Strings, 2019; Fuhlendorf, 2020a; Eknoyan, 2006). QI/BMI originated as a mathematical thought experiment intended to determine composition of “the ideal man”, not meant to be widespread, generalized nor used to indicate ‘good’ or ‘bad’ bodies or health status (Fuhlendorf, 2020a). Though Quetelet’s theories went on to contribute to scientific racism and racial classification, both harm and tools remain as foundational elements of North American health policy and practice (Strings, 2019;).

Use of BMI has been long debated, pointing to gaps in original studies and within BMI’s modern use (Campos, 2004; Guthman & DuPuis, 2006; Strings, 2019). For instance, gender and race were invisibilized when Quetelet created the index using mostly all white, male participant groups. “Within the medical field, theweight of racial Others was an entirely separate issue in the sense that racial/ethnic minorities were seldom included in medical analysis, much less the focus of them” (Strings, 2019, p. 195).

Continued use of such tools and theories reflects dominant views and values rooted in white, western patriarchy (Strings, 2019). As a result, notions of ‘good’ and ‘bad’ health and bodies play out in day-to-day life often going unnoticed or unconsidered. As a relatable example, during the early 20th century life, insurance policies and companies offering them discovered BMI and the tools earning potential (Guthman & DuPuis, 20016; Strings, 2019; CNN, 1998). Suddenly policyholders’ weight became indicative of good or bad health.

Higher weight led to higher cost of coverage but a decrease in options. “In 1998, The National Institute of Health once again changed their definitions of ‘overweight’ and ‘obese’, substantiallylowering the threshold to be medically considered fat” (Your Fat Friend, n.d.). CNN (1998) reported at that time “‘millions of Americans became ‘fat’ Wednesday-even if they didn’t gain a pound’ as the federal government adopted a controversial method for determining who is considered overweight” (para. 1).

As medical professionals, bolstered by these tools, continue to diagnose patients as 'obese',an increase in harm becomes visible on all bodies. "BMI cut-offs are used to deny life-saving and gender affirming surgeries… [and] is routinely used to justify client harm" (Haley, 2020) and marginalization. Fat activists and critics of these tools have received reproach for 'glorifying obesity' and undervaluing the health concerns and societal burden that comes with added flesh and a 'fat lifestyle' (Anderson & Bresnahan, 2012). On the contrary, unfolding all the pieces of fatphobia resurface the earlier notion of bias over biology. There appears an undervaluing of health concerns due to invisiblizing fat reality, perpetuating fatphobia and the 'obesity' narrative.

Intersecting Identities & Invisible Illnesses

Multiple and intersecting identities are often than not left out or overlooked during development of pharmaceuticals, therapeutic trials and treatments (Hewings-Martin, 2020). This practice of invisiblizing leads many in these communities to be mislabeled, mistreated and misdiagnosed in times of medical need (Hewings-Martin, 2020). I would further that hypervisibility of certain identities also creates distance from adequate care and an invisiblizing of real health problems. Several studies have documented theexperiences of female-identifying patients presenting with pain. Findings indicate that women are largely "met with skepticisms…lack of comprehension, [often] feel rejected, ignored…belittled, blamed" (Werner & Malterud, 2003, p. 1410) or have their condition assigned psychological explanation. Gender bias has more recently been raised as a concern in health care where commonly, the 180lb, white male is considered the average in research and study design and there is a lack of consideration for the 'non-dominant other' (Messing, 2014). Pharmaceutical use, specifically, can achieve differing results and responses from non-male patients (Liu & Dipietro Mager, 2016; Gordon, 2020). In 2014, consideration was finally given, at least in the United States, to the pharmacodynamic differences between the sexes, seeing zolpidem (Ambien™) as the first medication to have differential dosing for the sexes (Liu & Dipietro Mager, 2016). Biological distinctions and individual context are challenging to generalize. Not considering key elements like sex or gender becomes the norm in health and research spaces leading to incredibly harmful results (Messing, 2014).

One writer and self-advocate, Gabrielle Jackson (2019), while advocating for her own healthcare, identified ten chronic pain conditions that are typically ignored, underdiagnosed and widely plague, predominantly female North American patients (Jackson, 2019). Conditions include, but are not limited to endometriosis, fibromyalgia, chronic fatigue syndrome, painful bladder syndrome, irritable bowel syndrome, migraine headache, chronic tension-type headache, temporomandibular joint disorders, chronic lower back pain and vulvodynia and affect at least 50million Americans (Jackson, 2019). Within Canada, a report by the Canadian Pain Task Force (2019) suggests that while 1 in 5 Canadians live with chronic pain, the occurrence and severity of these conditions are greater for women, BIPOC, LBGTQ2S+ and impoverished communities(Allan & Smylie, 2015).

When a patients' symptoms are dismissed, told "it's in their head" or they are labelled mentally unwell instead of taken care of, patients begin to avoid medical spaces, health conditions and caring for themselves. Evidence shows that fat bodies and fat bodies with intersecting identities, "are less likely to seek recommended screening" (Phelan, Burgess, Yeazel, Hellerstedt, Griffin & van Ryn, 2015, p. 321) or other kinds of preventative healthcare treatment even when they believe they are in need of care. This includes screening for cervical,breast, and colorectal cancer, concluding that avoidance of care leads to outcomes that are less treatable, much more severe and even fatal (Campos, 2004).

Felt Stigma, a rationale for avoidant behavior in healthcare, is a term used by Phelan, etal. (2015) to describe the anticipation of negative treatment by medical practitioners based on past experience. Felt stigma has an impact on individual identity, esteem and overall health and is scientifically linked to increased levels of stress hormones (allostatic load) in the body (Phelan, et al., 2015). Both felt stigma and increasing stress hormones have immediate and long-term effects on health and healthcare (Phelan, et al., 2015). Physiological effects such as heart disease, stroke, depression and anxiety disorders, diseases that have been found to disproportionately affect 'obese' individuals, have all been empirically linked back to perceived discrimination, stigma, shame and avoidance (Phelan et al, 2015; Guassora, Reventlow & Malterud, 2014; Lee & Pausé, 2016). The outcomes of negative doctor-patient experiences, like felt stigma, further push fat bodies into the "good body/bad body" archetypes, begging performativity within the medical interaction. Even if a fat person gathers the courage to enter the doctor's office, they may feel pressure to withhold facts or inflate details in order to maintaindignity and honor and avoid shame (Guassora, Reventlow & Malterud, 2014).

Other unconsidered physiological factors play a role in a fat persons' treatment and outcomes in the medical space. One formerly unconsidered area examines hypertension (high blood pressure) diagnosis and treatment. As many as 30% or more of patients who have been diagnosed and treated for hypertension are misdiagnosed and have received unnecessary treatment (Dobson, 2003). High blood pressure and heart health, while important, are more oftenlinked to ‘obesity’ and more commonly misdiagnosed amongst fat people (“Suffering from high BP”, 2017; Dobson, 2003). ‘White coat syndrome’ or ‘white coat hypertension’, an artificial increase in blood pressure as a result of medical space or doctor interaction, has been found to be the leading cause of misdiagnosis (“Suffering from high BP”, 2017). Alternative explanations point to improperly sized or outdated equipment or manual over digital techniques which increase the chance of human error. Incorrect cuffs can yield inaccurate result typically because of sizing issues but also because the added tightness induces pain creating the paradoxical effect of raising blood pressure (Dobson, 2003). Another angle on blood pressure considers the experiences of racialized individuals. A correlation has been found between high blood pressure and the medical experience rather than actual health status. Studies examining empirical research on stigma and discrimination in healthcare found a sustained association between negative (racist) events and blood pressure reactivity (Williams & Mohammed, 2008).

Social and medical spaces have been working to unravel bias within scientific evidence. Despite these efforts, it seems much of the evidence supporting alterative narratives of fat are attributed to junk science and self-delusion. Most recently, Obesity Canada’s public engagement director, Ian Patton (2020) authored an article in response to a local fat community’s alternative narrative. A fat acceptance group located on Vancouver Island released a commentary critiquing the recent guide (Wharton et al., 2002) recently labelled “obesity deniers to the level of anti-vaxxers and flat earthers” (para. 7). As one of the authors of the community article Patton criticizes, I offer my own analysis of maintains its own kind of denial or paradox claiming ‘obesity’ is adisease while on the other hand trying to co-opt fat acceptance principles of body size and weightnot equating to health.

These notions are contrary, binary and central to the continued oppression bodies are subjected to in medical and social spaces. Additionally, these claims lack critical, intersectional analysis and disregards deeply rooted racist and colonial origins.

From Fat Health to Fat Futures & the Broadening Social Narrative

The last several years have seen space occupied in different ways by fatness and fat bodies. One shift I have noted has been a diversifying of 'mainstream' body representations and the dawn of the 'body positivity movement'. Body positivity, for critics of fat acceptance, often seems to be a more acceptable form of representation. However, it remains rooted in self-esteem where body size and positionality doesn't matter as long as you demonstrate the right kind of confidence (Gordon, 2020) and usually the right kind of clothing, brand or products). Earlier notions of recourse, barriers and exclusion ring similar to the type of self-esteem being conjured through body positivity movements. There appears a distinct tone housed in 'just try' or 'pull yourself up by the bootstraps' that disregards intersection and remains laden with racist, capitalist and patriarchal influences. With varying degrees of overtness and subtlety, social and dominant messaging have centered whiteness, western norms and standards and through the privileging of bodies that are more oftenheteronormative, thin, 'able' and cisgender (Severson, 2019).

Just as these supposedly new and changing narratives are ever evolving through social spaces and media, older messaging remaining at the surface. More common regulatory representations of fatness proclaim that fat bodies must be unhappy with themselves, always working towards change or positioned as spectacles (Gordon, 2020). Narrow views of the fat experience are further evidenced by shows like well-known and long running reality TV series, *The Biggest Loser* (Broome, Nelson, Roth & Silverman, B,

2016) and *My 600-lb Life.* These two series have invaded major networks for seventeen and eight seasons respectively and have maintained a mainstream audience on North American television for years (Denhart, 2020; TV Guide, 2020). Weight-loss and other fat archetypes have been permanently affixed to the fat body and are representative of the few timesfat bodies are deemed acceptable to be *on* major network television. Multinational mass- media conglomerates distributing entertainment, such as cartoons, have capitalized on the villainizationof fatness, while other performances maintain fat-as-a-joke or weight loss narratives.

Fat villains, jolly jokesters, and fat dieters all support the construction of the good versus bad body and the idea of a “good fatty” (Cameron, 2018). The “good fatty” or good fat body must engage in performativity, that is, continually demonstrating their worthiness through movement, healthy food choices or engagement in fitness and weight loss processes. Cameron (2018) points to another major reality television series, *My Big Fat Fabulous Life*, which depicts the active fat body as an acceptable form of fatness, “measured according to normative standards within a weight-based paradigm” (p. 260). The central participant of the reality show positions herself as a former slender dancer thus demonstrating temporariness, acceptability and regulation. In TV shows perpetuating performance of fat worthiness and positioning fatness as something to be overcome, fat stigma and ‘obesity as a disease’ become central (Cameron, 2018).

Through this research, it has become apparent that there is a growing desire for options and representation within online communities. But online spaces that once provided refuge, direction, validation or support have been co-opted by fatphobia. Algorithms seem to force users into a place of regulation and shame despite their attempts to find solitude or acceptance. YouTube, home to the social influencer and social outcast alike, willsandwich videos made by on fat acceptance between celebrity rants promoting fat shaming and videos demonstrating 'how to lose weight fast'. Simply searching 'fat acceptance' on YouTube provides a litany of anti-fat opinion pieces framed by archetypes of fatness and a litany of fast food. Take a look for yourself. It is worthwhile to make mention that one widely followed celebrity that loudly supports fat shaming and dehumanizes fat women also makes content complaining about 'fit shaming' orbeing shamed for overly attending to physique and fitness.

From many of these viewer and content creator perspectives, fat acceptance is a lowering ofthe bar. It is a belief that fat bodies are just upset they can't be fit or looking for a last chance alternative after giving up on dieting. Content creators, who won't be given space in this work, release video after video positioning themselves as concerned about the health of fat bodies and their impact on society and economy. At first, they didn't seem to be getting anything out of taking this stand against fat people, excepta platform for their own fatphobia and stigma. YouTubers had figured out what insurance companies had all those years ago: That with fatness, and especially fatphobia, came earning potential. A growing and never-ending society of fatphobia supplied content and maintained the ongoing stream of revenue.

When it all Comes Together: Concluding Chapter Two

The fear of fat pervades social norms, medical spaces, educational interactions and political realms. Millions of dollars are spent a day in North America to decrease body weight orincrease access to potentially hazardous pharmaceuticals and surgeries (Campos, 2004). Perhaps instead, the work must aim to decrease, decenter and eventually dismantle fatphobia and weight bias in healthcare and society as a whole. Labelling every fat body as diseased based on proportionality or added flesh ignores what should now be obvious: All bodies are different; the conflation of size and health is unscientific and misguided and results in dangerous and devastating consequences. The ways North American society has come to understand and take up the 'obesity' narratives and fatphobia rests upon anti-Black racism, assimilation, regulation and the earning potential of bodies.

'Fat' isn't a Word that gets Scolded Away with the Same Ferocity as 'Fuck'.

A year spent submerged in this topic, this word, this feeling: Fat. Children in North America learn this word and feeling early, learn to avoid it and arm themselves with it as an acceptable insult or observation. Through this process of iterative research, writing, holding space for the personal experiences of others, I've started to let go of old harms and belief systems and see 'fat' in a different way. Through this work, I have come to see both 'fat' and 'obesity' as social constructs;socially constructed ideas, created by and for white, European and western colonizers and capitalists. 'Fat' and 'obesity' narratives are constructed *upon*, weaponized *against* and capitalizing *on* all bodies.

The social construction of fat bodies has only served to further marginalize and oversimplify all bodies, their lived experiences, voices and realities (Cooper, 2016). I am not the first to state that 'obesity' is a social construct. Many others including Honeycutt (1999) made this claim central to their dissertation work during the late 1990's and less than a decade later Pieterman (2007) made a similar claim. The body of literature and the history of activism within the fat community goes back decades, and certainly longer, yet fatphobia remains rampant withinsystems and fat acceptance and the diversity of the fat community is still unknown. Not only do the education and medical system need to be reconsidered, but how we speak of and aboutbodies is more integral than it has ever been.

By acknowledging the socially constructed nature of ‘fatness’ and the racist history of fatphobia, all bodies have an opportunity to avoid being silenced by white, western, patriarchal and misogynist standards that have come to infect our society. ‘Fat’ acceptance and ‘fat’ liberation movements increase this visibility and the visibility and harm that BIPOC and 2SLGBTQIA+ people have shouldered for so long. Highlighting and re-narrating the dominant stories being told, there will be less space for discrimination and systemic violence to hide. Therewill also be less space for the suffering of bodies, denial of human rights and the creation of a pathway which with to begin undoing the harmful and humiliating histories these communities carry.

Chapter Three: METHODOLOGY

Introduction

Thirty-six years ago, self-described “Black, lesbian, mother, warrior, poet”, Audré Lordewrote a powerful and impactful essay, in which Lorde (1984) asserts that masters’ tools:

> …For the master’s tools will never dismantle the master’s house. They may allow us totemporarily beat him at his own game, but they will never enable us to bring about genuine change… Racism and homophobia are real conditions of all our lives in this place and time. I urge each one of us here to reach down into that deep place of knowledge inside herself and touch that terror and loathing of any difference that lives here (p. 113 of *Sister Outsider*).

With these words, Lorde (1984) was acknowledging that oppression cannot be disrupted using the same logic that justified or produced that oppression in the first place. Lorde (1984) speaks to standing alone “unpopular and sometimes reviled” (White, n.d., para 6.) to bring aboutcommon cause, new structures “in order to seek a world which we can all flourish” (White, n.d., para 6.) Settler- driven research done *on* those who have been marginalized and their communities has been harmful, damaging and contributing to the ongoing reproduction of paternalistic policies and systemic oppressions (Smith, 2012). Within Canada, this type of research has produced national policy aimed at dictating to and indoctrinating Indigenous Peoples contributing to significant disparities in health between Indigenous and non-Indigenous citizens. In Canada, the *Indian Act,* established in 1876 and largely retaining its original form in 2020, is an example of settler-driven, ‘research-based’ federal law laden with colonial, assimilative, and discriminatory practices (Act I. Indian Act, RSC 1985, c I-5. 1876).

As a student researcher of mixed Indigenous and settler ancestry, I am influenced by my Indigenous teachings as well as what I have learned from western academia. When I consider what it means to approach research differently, from a decolonial or Indigenous lens, I consider the inclusion of self in that research versus western notions of distance and separation from subject(s), 'rigor' or bias. Decolonizing research is driven by and for communities asking for support and is a call for counter-practices within all frameworks, western, Indigenous and otherwise; practices that do not privilege one view over the other but enable all people to make sense of their own reality (Absolon & Willet, 2004). I do not believe we can separate ourselves from our research, an idea that upholds the supposedly unbiased approach of western scientific frameworks. Scientific or evidenced based frameworks can no longer maintain the claim of beingcompletely value free and it is necessary to challenge the primacy of these approaches in healthcare research.

Hawaiian scholar Dr. Julie Kaomea (2015) stated that one's research framework and methodologies should "stitch together a rich tapestry of analyses that privilege [BIPOC] perspectives…and speaks back to Western domination" (p. 3). More simply put, "to tell differentstories, we need different research methods" (Kaomea, 2015, p. 23). The work of Kaomea (2015), Kovach (2009) and Archibald (2008) encouraged a different approach in this thesis, inspired by a personal longing for alternative perspectives and desire to find more ways to push backagainst western dominant discourse. In Chapter 3 and throughout this work, a decolonial lens forms the rationale for the use of Indigenous and qualitative approaches. The following chapter will aim to articulate the thinking and perspectives behind *Fat Bodies in Space* and identify tools and processes used to create and execute this research.

Methodology & Methods: 'The thinking behind the doing'

Aimed at uncovering fat narratives, *Fat Bodies in Spaces (FBS)* is a qualitative study grounded in a decolonial research paradigm drawing from both Indigenous and western paradigms. Approaching the work from this perspective made space for the support of Insurgent Story work, Narrative methodologies which felt most suitable for a study interested in uncovering alterative narratives through non-hierarchical references for these methodologies. Reflecting on these concepts, I sought ways to centralize Indigenous and decolonial values which honor participant contributions of stories and knowledge. Māori scholar, Dr. Smith (2012) indicated that attempting to participate in decolonial research requires "seeking to effect…change and engage with imperialism and colonialism at multiple levels" (p. 20) and emphasized the significance of "revealing and dismantling colonialist power in all its forms" (p. 20). This way of conducting research felt particularly in alignment with the literature-as-research-method and the fat communities' indications of entrenchment in a multi-system struggle with oppression.

FBS engaged participants in narrating new stories, often working to challenge past dominant narratives that have been used over time to justify occupation and domination (Gaudry,2011). Cree and Saulteaux researcher Dr. Margaret Kovach (2009) stated, "while critical theory and postmodern analysis have created space within western science for representation, voice, and a multiplicity of truths, the essentialism of Western thought pervading research has not been fully challenged in the academy" (p. 28). In order to confront binary western essentialism this work aimed to weave representation and multiple truths from inception to the relational gathering of silenced voices and truths, and eventually inclusion of my own story in this work and process.

Aligning with the notions of relationality and trust within her research, Kovach (2009) established the conversational method which utilizes fewer formal tools such as conversational interviews and reflects an understanding that “narrative is viewed as story and is seen as a “modeof knowing” (Kovach, 2009, p. 43). Kovach’s view on narrative as story encouraged the collection of stories as ‘data’ for this research work. In many Indigenous communities, stories, both mythical and event-based, are passed through generations as a means of knowledge transfermeant for sharing responsibilities, principles, ways of being, teachings, medicines, and histories (Kovach, 2009, Archibald, 2008). As a method, narrative inquiry also views stories as tools that allow researchers to uncover, understand, and develop solutions to complex social processes (Daiute, 2014). Within these narrative approaches, stories are seen as something that exist *as* culture while also actively *producing* culture (Daiute, 2014). By utilizing narrative approaches, I wanted to avoid recreating dominant and oppressive methods and contribute to the building of space for realities that exist outside the dominant discourse.

Storywork (Archibald, 2008) as an addition to this research framework provides opportunity to see truth and narrative as subjective and uniquely individual. Stol:lo scholar, Joanne Archibald (2008) evolved Storywork as a research method from the teachings she received from communities Elders who emphasized the significant work that has yet to be done within the communities and the importance of, seriousness of and reverence for the living, breathing stories that develop from this kind of work. Archibald’s (2008) principles for engaging with Storywork describes seven tenets: respect, responsibility, reverence, reciprocity, extending to wholism, interrelatedness and synergy. These tenets acknowledge the criticalness of building towards relationships with research participants, and that the research interaction is about holding and sharing space, not about the extraction and interpretation of information and knowledge. Archibald's (2008) Storywork teachings allowed this project to engage participants in a reflective process of sharing and guiding, which helped create space for each of them to direct the conversations how they wanted and towards the stories they felt were being told about their bodies and identities.

Developed by Métis scholar Dr. Adam Gaudry (2011), 'insurgent research' contributes to the decolonial paradigm as an opportunity to center those living, breathing stories, empower individuals and communities and to create a change in social and medical systems and discourse.Insurgent work takes up decolonization by challenging the status quo and building upon collective and relational action. This paradigm can be applied with over-researched communities in contrast to extractive research, or research that "perpetuates outsider perceptions" (Gaudry, 2011). Developing these actionable components alongside participants during a brief study can be daunting, however the emphasis on relationality within Indigenous research methods providesopportunity within this work to avoid hierarchal, outcomes-driven frameworks.

The stories of the fat community have long been rewritten through the medicalization andcommodification of bodies. Indigenous ways of doing offers opportunity to create space for visibility and the development of practice and narrative that is respectful and neither harmful nor pathologizing. These ways of sharing through story have engaged diversity and contributed to social development for generations but are often set aside in favor of research that is considered evidence-based and scientific. Western domination and dominant narratives impact the daily lives of those living in fat, queer and BIPOC bodies. When dominant narratives go unaddressed and unchallenged the realities of these communities becomes merely represented through skewed statistics which fail to capture the diversity and uniqueness of human experience.

As Audre Lorde (1984) identified in her impactful and influential essay, dominant tools are not the way forward. Approaching research from this lens encouraged further broadening oflens I had chosen to employ. There came a point in this research process, many months after theinterviews and analysis were completed that I realized, despite efforts to refrain from recreatingwestern forms of research, I had, for the most part, done just that. I had worked to keep myself out of the process, tracking thoughts and feelings that arose throughout, but always maintaining distance and separation. During that time, I was also engaged in my own healthcare process and a weekly entanglement with the medical systems. It was in one of those moments that I came to see how far I had distanced myself and realized how I could correct it. I was part of this research. I am this 'demographic' and creating separation was unnecessary. I acknowledge that this work is not value free, nor does it strive to be.

Autoethnography as a method provided a means to be both part of the process and the product of this research and acknowledges the ways in which personal experiences and values come to influence the process (Ellis, Adams & Bochner, 2011). Dr. Paul Whitinui (2013) speaks from a place of Māori knowing and reframes to 'Indigenous autoethnography'. Dr. Whitinui (2013) indicates that Indigenous autoethnography can act as a "culturally distinctive way of coming to know" who we are within the research agenda and resists "ideologies that limit our ability to participate fully as Tangata Whenua (people of this land") (p. 460).

Just as researchers of the past believed gender had no influence on pharmacological outcomes, scientists have long held superiority on the basis of being able to ‘unbiasedly’ produce‘reliable’ and ‘valid’ ‘truth’. ‘Truth’ that has come to dictate and indoctrinate. These tools, waysof knowing and doing, allow me as a researcher to write about the culture or identities I am part of and that are part of me. Challenging normative processes and ways of doing has the potential to illustrate and learn from social and cultural facets that haven’t been given much considerationin dominant spaces.

Doing: Research as Action

Recruitment

Four volunteer participants were recruited from two online support forums (Facebook groups) that discuss the health and care of fat bodies in a space that is intersectional and focusedon fat liberation (Freespirit, 1973). The online groups were created upon these and the tenets of queer theory and fat acceptance movements and group moderators require active members to refrain from weight-centric, gender specific and fat-phobic conversations within the group.

Initial ideas for this sample group were generated from my own participation in online spaces, and permission was granted from the online groups and group moderators to seek participants from within these private/membership-only spaces. Given that this project includes participants recruitment, an ethics review (Appendix A) and participant consent (Appendix B) were also necessary prior to the start of the research and interview processes. The sample size, as per master’s thesis protocol, originally sought four to six participants. Following 3 weeks of online recruitment, sixteen individuals volunteered their participation. Maintaining a local sample saw that twelve early volunteers wereexcluded due to their location (outside of Vancouver Island, B.C.).

Inclusion criteria for this study required that participants were adults (19 years of age or older), were currently or have recently accessed health care within Canada and are residents of Vancouver Island. Additionally, participants were specifically recruited from a fat liberation community Facebook group where membership is dependent on fat self-identification, understanding of fat liberation and commitment to non-pathologizing/weight-loss discussion. The exclusion criteria were minimal and based on logistical need requiring elimination of those unwilling to provide consent or anyone residing outside of Vancouver Island. In alignment with these parameters, all of the participants live on Vancouver Island, with the exception of Participant #4, “M”, had more recently moved to the mainland after growing up on Vancouver Island. For reasons unrelated to their weight, all of the participants had relatively consistent access or need for access to health care over their lifetimes including at present. Though none of the participants addressed race in their stories, several acknowledged gender, specifically experiences of the trans and female communities and the particular barriers they are facing within health care spaces. However, the complexities of gender often get overlooked as a result of binary systems (Driskill et al., 2011). Though some participants self-identified or disclosed identifying information in various ways, I did not requestdemographic related information from them during or after the interviews. I approached demographics from the perspective that requesting or asking about a participant’s gender, for instance, was less relational than the option of providing space within the interviews for the individual to share who they were in their own way. Given that participants spoke to experiencesacross their lifespans, I avoided requesting age-related demographics. Taking this approach aligned with my desire to circumvent connotations associated with overarching terminology, such as ‘school-aged’, or ‘young adult’, which I find to be of little use. Using these terms and classifiers in research inevitably leaves a gap for people who fit between the categories, or for whom there are no good categories. ‘Not fitting’, or marginalization, increases exclusionary outcomes and barriers to supports (Driskill et al., 2011). One example of this is government funded ‘student’ summer employment programs, available only to those under the age of 29. There is a growing force of mature students who are struggling between semesters to find employment opportunities that align with their school priorities. In my own experience, this can lead to accepting jobs that are short term, do not support academic goals or a lack of opportunity and income between semesters.

Though the purpose of demographic collection is to seek clarity and indeed classification, demographics can inevitably become further forms of marginalization (Atlantic Council, 2020). Many individuals and communities fall between the cracks of categories, inflating the importance of dominant groups where instead they are meant to create inclusion and opportunity. Engaging participants in a non-demographic way helped, in this project, to illuminate population groups that might not have been otherwise considered. This said, self-reported demographic information (racial, cultural, gender identities, age group, etc.) offered by participants during the interviews will be considered throughout the analysis process. This will allow participants to report on the details or identities that are important to them, not be automatically linked to categories created for ease of reporting or statistical purposes.

Sampling

A convenience sampling method (Naderifar, et al., 2016) was used to identify these four participants from the online forum. This sampling method was helpful to access participants by means more available to the student researcher and assisted in making connections with populations who may otherwise be difficult to approach (Naderifar, et al., 2016). Arguably, the individuals inhabiting fat bodies are not difficult to locate themselves, but this is also a subjectiveand often individual notion.

Seeking volunteer participants from an online fat health group built on an understanding of fat liberation was intended to minimize any mental/emotional risk that could be created by ‘advertising’ the project in potentially unsafe public spaces such as hanging a poster or receiving information through an email mailing list. This was indicated as a risk due to the ingrained and insidious nature of fatphobia. I believed that the language of this study and use of the term‘fat’ may not resonate for some individuals or may feel harmful to others. Simply viewing the word may have an impact for someone who doesn’t use it, for someone who is struggling with disordered eating or their mental health.

The convenience sampling method also provided space and distance for voluntary participation and self-identification. As a tool, it supports the work in avoiding classifying or labelling participants for the study. Finally, this method allowed space to recruit individuals who self-identify with characteristics of the study without interference of labelling by the researcher. Implementing this sampling method, a brief post indicating expectations and details was uploaded to two Facebook groups (Appendix D). Names, time and date of contact and the person’s email address were collected from each interested respondent viacomments on the thread or private message. Participant information was charted based on date and time, and participants were chosen on a ‘first come first serve’ after applying elimination criteria.

Consent

It was the goal of this project to develop a format of ethically viable but relatable researchconsent. One study examined ways to "better address [consent] through ongoing discussion [rather] than through an external evaluation of potential risk" (DePalma, 2010, p. 215). Other researchers support this concept, suggesting that "consent is obtained not only prior to opening the evaluation effort but as information is uncovered and shared; as power relationships shift, this consent must be renegotiated continuously" (Guba & Lincoln, 1989, p. 218). For the purposes of this work the first level of consent was achieved through voluntary participation, rather than being approached by a researcher seeking to elicit participation. Participants self- identified as a candidate for participation and contracted from their own volition for this research. Following the first connection which included a review and explanation of inclusion and exclusion factors, participants were offered more information about the details of the study, what their role may be and what questions would be asked of them. All participants signed a consent form prior to the interviews, and there was an opportunity to identify any roles, responsibilities, expectations or concerns the individual participants may bring to the project. The consent process was meant to build a basis of relationality between the researcher and participants, creating a parallel process devoid of hierarchy and performativity, like feeling the need to find or give 'the right answer'. The consent process continued during the analysis and writing stages where participants had an opportunity to read and request changes on the sectionsthat detailed their stories. Two participants asked for minor changes to details and pronouns, and each change was made as requested. There were no requests for exclusion of information.

Pseudonyms, letters or names are used to identify participants throughout this document andwere chosen by each person at the beginning of the process. Along with opportunity to offerfeedback on the write up of their personal stories, participants were given the chance to reconsider or change their pseudonym or identifier at any point. Each participant was part of ongoing communication throughout this project and had the opportunity to engage in the iterative process through review and feedback, at each stage of analysis and writing.

Data Collection: Gathering Stories

Data collected for this project was in the form of participant stories, gathered via conversational and Storywork methods. All participants were given the opportunity to engage in one on one, face to face interviews, but plans were changed for the fourth interview. Due to the current COVID-19 pandemic, myself and the fourth participant re-evaluated and decided together to go forward over the phone. Interviews were conducted in a space of each participant's choosing, aiming for reduced noise and distraction. Prior to and during the interview, participants were encouraged to discuss only what they were comfortable sharing andwere assured they could end the conversation and withdraw at any time without consequence.

All interviews were audio recorded and personally transcribed verbatim for analysis and copiesof each were offered to every participant. Minimal notes were taken over the duration of the interviews, mostly resources and recommendations (such as books or podcasts) in order tomaintain focus and presence with the participants. Given the objective and purpose of this thesis, and the goal of reimagining health and care for those existing in fat bodies, several interview questions and prompts were used to enablethis focus and engage individual understanding and perspective. Questions (Appendix E) were provided for ethics review and to participants prior to and at the time of the interview. Confidentiality was upheld at this stage through immediate removal of any identifying information on all documents digital and otherwise. A system was maintained to organize participant data, labelling each participant with a number so their contributions were confidentialand not misattributed.

Following this process, autoethnographic elements were captured using the same collection methods with myself positioned as the participant. A trusted community member with no affiliation to this study acted as interviewer and guided me through the same questions and process I had worked through with each of the four participants. This interview was also audio recorded and transcribed verbatim for analysis.

Introduction to Analysis

An in-depth description of the analysis process is outlined in Chapter 5. However, this section provides a brief background of analysis methods used, including narrative and thematic approaches. The analysis framework is supported by an Indigenous research paradigm and understood through the teachings of Elder's and mentors. Long before academia and research applied in this way, Indigenous ancestors looked to the land for guidance and knowledge production. The land, seasons, stages of growth in animal and plant relations, all informed a wayof being, legal order, ethical principles and educational and governmental systems. When it comes to applying these teachings to qualitative inquiry, I was taught by Anishinaabe researcherDr. Billie Allan to take a "bush and berries" approach (2018), where you examine the detail and intricacy of each piece (berry) before stepping back for a broader perspective (bush). I have applied this teaching to explain the forms of analysis used, how these methods assisted in developing participant stories and the benefit of using them in combination.

Berries

Narrative analysis as a form of qualitative inquiry is an opportunity for stories to become data as the researcher centers in on the reality of each individual (Buttina, 2015). This form of analysis is concerned with *how* and *why* and seeks to better understand human experience, culture or identity. Narrative approaches to analysis can be characterized as unstructured tools that can provide depth and context to features emerging from the participant's life stories and contribute to "reconstructing social events from the point of view of informants" (Muylaert, Sarubbi, Gallo, Modesto, Neto & Reis, 2014, p. 184). Narrative analysis applies a narrower approach, asking how individuals have come to understand the world and themselves, how that isrepresented in their ways of being and why ideas are being presented or communicated in a particular way.

Bush

Thematic analysis grows from processes of inductive and deductive reasoning, unexplored queries and information gathered from literature. It allows for the identification andanalysis of central ideas and patterns (McAllum, Fox, Simpson & Unson, 2019) and guides thebroader scope of analysis. Thematic analysis facilitates this process through the examination of patterns and themes, seeking to capture important concepts within and across data (McAllum,Fox, Simpson & Unson, 2019).

Thematic and narrative methods work together to gather and explore multiple perspectives. Broadening the scope of analysis invites connections to be made between participant stories and the systems and structures being navigated within. Multi-level analysis promotes alternative perspectives and makes space to build new futures for individuals fat andotherwise. An initial application of these methods was used to build the stories featured in Chapter 4 and themes are unpacked and discussed in Chapter 5 and 6 respectively.

Chapter 4: CONVERSATIONS

Resources discussing methods of narrative presentation describe taking on the voice of the participant or writing a story *about* them. Instead, in the stories below, I worked carefully tomaintain the voice and tone of each participant, offering a reflection of the exchange and time shared with each individual. As a result, the stories are written as my own narration of that dialogue interspersed with direct quotes to demonstrate the context and authentic flow of conversation. As stated, these sections were written with support of data collected (recordings, transcriptions and notes) taken throughout the interviews and research process. The writing of participant stories took place prior to the main analysis, coding and theming process and were used as well as the notes and data collected in identifying those codes and themes. This chapterbegins with the four participant stories and concludes with my own narrative.

Participant #1: "C"
"I'm glad you like your tummy roll, but it's not a social movement"

"C" was the first willing participant, a younger, animated individual who identified as living with a disability and, by all accounts, had taken their health and care into their own hands."C's" identity as a trans-masculine person was reflected in much of his story, often central to both the positive and negative experiences he has had within the health care system on Vancouver Island. In response to my asking about his interest in the project, "C" told me:

> *Yeah, I saw it and thought… it seems like important work, um, being trans and disabled, I've definitely run my course through the medical system, and continue to do so, and I think that my fatness has definitely impacted that um a lot more when I was younger…. Especially when I was-before I medically transitioned, and more so when I was presenting female fulltime…had breasts at the time so I was curvier and…but yeah. I hada*

> *really rough time accessing any medical care.*

From the beginning of our conversation, it seemed that "C" had a clear-cut style of self-advocacyand knew how to be matter of fact and to the point. But through his story, I learned that this had come only after a long history of family fat shame, imposed dieting and struggles with disordered eating. Despite this history, "C" discussed his experiences with disordered eating openly with me, and with his doctors.

> *I still struggle with disordered eating patterns to this day... And I told her [the doctor] right away, you know, that 'I've been struggling with these eating habits that I think aren't healthy and are disordered and if we could not talk about my weight as something-moveable, that would be great'. And she's been really awesome about not bringing it up.*

"C" attributed his openness in that medical interaction to having found a "*great doctor*" who was"*awesome about not bringing it up, asking me if it's okay if she weighs me when she has to, and telling me to turn around so that I'm not watching the scale*". Finding a "great doctor" coincidedwith "C's" discovery of fat acceptance. Fat acceptance wasn't something that "C" had always known about, nor was the idea that anyone might even be *allowed* to think outside of a weight- centric paradigm.

> *But it made a huge difference…Online spaces were revolutionary. I've met some reallyawesome people and realized that some of the people that I did know already were on board with this[thinking] as well. And like, I had no place to go for those kinds of resources before. So, it's been a really educational experience.*

But before honing his self-advocacy skills or learning of fat acceptance, it was rare that healthcare experiences were positive for "C" and they typically remained focused on weightinstead of what might really be going on with his health.

> *I was told that the pain that I was experiencing was you know, imaginary, or a result ofbeing too heavy and that it would go away if I was more active. And I think I ended up making it a lot worse, just kind of powering through, and it wasn't until recently...So mydoctor now has taken me*

> *seriously, about it.*

Not being believed by his doctors was additionally injurious once coupled with "C's" challengesaccessing care as a trans person. "*When I was 16, I... At that point I had started to figure out that I was trans, but coming out was difficult, and I was doing it over and over again, and I wasstill presenting as my assigned gender".* Existing in a fat body only added to those painful encounters and for "C", a lack of access mounted.

> *I finally got my mom on board with the idea that I needed a breast reduction…And I remember going to see the doctor for a referral for that…then I remember he came back into the room after having weighed me and told me like, um, he told me 'your BMI is too high, we can't refer you for a surgery. It's not safe to perform a surgery on you.' And thenhe started talking to me about getting a lap band, which you might know, is a surgery!*

In that moment "C" realized this was about more than adipose tissue. What was meant tobe an "*amazing and fantastic*" period for "C", starting hormones and beginning his transition, was marred by a lack of eligibility for top surgery unless he lost weight immediately, a fact he knew to be untrue. "C" told me he was lucky to have a support system but still struggled with "*internalize[ing] this idea that like, "oh, well if I was really serious about transitioning, I wouldjust be 'good enough' to lose the weight".* At times this belief was mirrored by even his biggest supports in the trans community, who saw weight-loss as one of many hoops trans folks have tojump through due to medical gatekeeping. Initially deterred, "C" tried in vain to diet, but eventually realized it came down to asking the right questions.

> *There were a couple more instances where I got turned down...but eventually it was communicated to me that it was the surgeons themselves who had a BMI requirementto do the operation and so eventually I was able to ask like, 'ok, who doesn't have that?' And I was able to see an amazing surgeon! ...I didn't lose weight and I did get top surgery!*

Even though this was a win for "C", top surgery did not come quickly or easily. He had to push past doctors who insisted if he "*ever wanted to get that done*" weight loss was the only way. "C"told me that one doctor "*even [went] so far as to tell me that if I lost the weight… I wouldn't want the reduction anyways because losing weight would shrink my chest...but...Yeah...A) You don't know necessarily that it would shrink my chest and...and B) Yeah, I still wouldn't want it... [laughing, pointing to chest]".* "C" also wanted me to know that the option of top surgery has only recently become available in B.C. (approximately the last fiveyears) because more practitioners have begun offering gender affirming care.

Having been part of the healthcare system in this way, "C's" journey seems to have shaped his approach and outlook on life, politically, socially and academically and his willingness to share this journey in order to support others. At the conclusion of our time together, "C" left me laughing but also incredibly valuable insight on the systemic nature offatphobia, as he sees it, both within and outside of healthcare systems.

> *I don't think it's something we can just change in the medical framework, because obviously that has to change, institutionalized fat phobia is a huge problem there. But Ithink it's co-morbid with the societal repulsion we have towards fat bodies. I don't necessarily know how to change that. Um. Make it illegal to have visible collarbones? Idon't know! ... I think obviously race and size are not the same, but there's a huge link between racialization and fat phobia. You can paint a similar picture whereby paintingcertain health problems that we see as problems that are linked to obesity, rather than problems linked to stress, lack of resources, lack of access to various needed things. General mistreatment by society, refusal of medical care, less access to medical care. When you account for all of that, by painting it as a problem with weight I think we really erase the root causes and erase our ability to then deal with those, so I think yeah ideally, we would stop thinking about weight and size and we would treat it as the corollary factor that it might be...*

Participant #2: "Leslie" [3]

> "***I've got, what I think are some pretty amazing credentials as a fat person who hasbeen investigating my own fatness and living it, but also an activist in it"***

It was important that the participants in this project had a say in the location and style ofinterview and, as a result, I was invited to meet Leslie in their home, where we had the opportunity to chat over gifted tea and berry crumble. From the beginning, Leslie's warmth andstories had me leaning in, and we hadn't even broached the topic of healthcare. Leslie had lived many years experiencing doctor's discrimination or disbelief before embracing fat and body acceptance. Storying this medical experience doesn't start in a doctor's office, but begins in some ways in a bookstore, with a gift card and a curiosity. I believe Leslie wanted to start there because of how it all truly interconnects. "*So, I think I want to just tell you my beginning, my involvement in fat stuff".* Leslie's involvement, as Leslie described it, took us to eastern Canada,to that bookstore and the discovery of a magazine for fat female bodied folks.

> *I went into the women's bookstore and they had this magazine called Radiance Magazine for fat women, or it said large women or something like that…and I had my gift certificate and I had bought a record, and I had 3 dollars left and the magazine was 3dollars…and the shame I felt, the resistance inside of me. I'd seen that magazine before, Iwas curious about the magazine, but this kind of closet I was in, this invisible glass closetwhere I wasn't fat if I didn't associate with that or didn't associate with other fat people. But I got the magazine, and it had articles in it telling me I was okay in the size I was. And I had never in my life heard that message before. I had never heard to love myselfthe way I was, or that I would be loved the way I was, or that I didn't have to try to be different.*

Leslie had grown aware of their fatness early on, specifically on their 5th birthday, and it became seemingly intertwined with Leslie's own family trauma around food and mealtimes. *"I've learned to eat while I'm stressed…I grew up on stress…at the dinner*

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[3] Participant #2 took part iteratively in the reading, writing and editing of their story. I've done the typing, but Leslieis very much the author *and* teller of this story

table, like...Yeah, I was *<u>forced</u>* *to eat".* Years later, feeling the need for change and inspired by *Radiance Magazine,*

Leslie led three other fat people in imaging, creating and eventually distributing a clothing catalogue, *Far and Wide*, for fat individuals. "*Not just clothes but books and jewelry and belts and bicycle seats and big size hangers and long measuring tapes...as much as we could. and hadthis grand time sourcing [products]...so we put together [the] mail order catalogue…'94 was our first issue".* As a tenant's right advocate and the only super fat body in the catalogue group, Leslie's next move was a trip to California, fully funded thanks to a research proposal they had done for the mail order catalogue group. This would allow the group to gather with and get to know a known fat rights group and other collaborators. California provided Leslie a chance to meet with the women behind *Radiance Magazine*, the pages that had shift the door of their 'invisible' fat closet.

> *So, I was out [of the closet], and they were all a bunch of dykes at Radiance magazine, they took me-one of things they did, was take me to their Sunday swim at the Oaklands pool and you had to be 200 lbs. to get in. And that change room was the first experience in my life that I felt okay and normal…And that was like -it was almost like I learned howto breathe that day.*

Over the years, Leslie engaged in fat advocacy media work- "*So, now it was the first timebeing able to speak as a fat person and I found my voice and you know…The pathway was comfortable for me…the fatness was…it really shifted fast".* This was when Leslie arrived on thewest coast, joined Big Dance, a dance class for fat bodies, was part of the Secret Fat Underground, a group by and for fat advocacy and change and with some of these groups, begantaking part in naked nighttime swims. But advocacy and acceptance only go so far in healthcare."*Yeah, so self-acceptance came from that, but my medical experience did not improve...um. that's been a journey...that's been a more recent journey*

I think, for me, is medical stuff".

Initially even with all of this experience to inform Leslie's body acceptance, they did not yetknow how to advocate to their doctor.

> *But she didn't get it. And I didn't know how to connect or speak my truth, at least not yet.To learn to speak my truth to anyone, I had to learn to step out of my shame and into my true self. Only when I am standing in self-love and self-compassion, can I get clear aboutwhat I need and what is appropriate. And then it's time to speak truth to power!*

Years of movement, dance class and pushing through led to the need for knee replacements and a new journey rife with discrimination, disregarding and judgment. Being shamed multiple times that weight had caused them problems and continued to put their knees atrisk, they were finally referred to a surgeon who accepted Leslie as he would anyone else in needof his services. And though the previous doctors had all refused to provide Leslie with new kneeson the basis that weight would affect replacement longevity, their surgeon told them: *"there is actually no empirical evidence to support that".* There was no evidence that Leslie's fatness putting the new metal knees at risk. Leslie got the care that was needed and reports of themselves: "*being thrilled their knees keep them stable and free from pain. That they can climb stairs, hike, dance and stand for long period of time like they hadn't for years".* And I would further, if their okay with it, that Leslie rides a bike. Everywhere.

This was where Leslie told me of the health care wants and needs that arose: access. "*I don't want to put healthcare in a box. So, healthcare to me is access to physical activity and access to healthy food as much as it is access to doctors. It's also accesses to alternative practitioners. And all the things that don't fit"*. Need for proper fitting medical supplies and equipment presented challenges after knee surgery. It was stationary bikes they couldn’t fit into to the medical waiting rooms without chairs to accommodate hips. When Leslie’s surgeon recommended compressions stockings, Leslie ultimately purchased 9 pairs that didn’t fit. Even a‘custom stockings’ company refused to adjust or measure for Leslie’s thighs. There was no accessing waterproof athletic clothing in their size, leaving those metal knees wet, cold and sore while commuting on that bike. During this time, Leslie supported a larger friend trying to accessan MRI test. Over 300 lbs.? No machines in Canada for you.

From their personal and allied experience, Leslie asks for sensitivity, reflecting on past stories of waiting room discussions and unprofessional screening procedures. *“I remember I once had a mammogram that had a shadow and so I had to go get an ultrasound and the…And the practitioner looked at me and said, "how am I going to find anything in those breasts?" And there I am... like already on edge”.* Leslie spoke of the change’s health care practitioners need tomake to be around fat bodies specifically, but also overall: “*attitudinal change in relationships between health care provider and recipient”*. Leslie recognizes that *“all my life things have beenassigned to me because I’m fat”* and they’ve been stigmatized and not believed as a result. But Leslie continues to be an advocate, find alternatives and stopped listening when doctors say “should” in the hope that we can all be looked at as a community*. “Looked at as a collection of people who've collectively had similar experiences. We need to be asked. From our lived experience comes the wisdom to understand how we can be properly supported.”*

Participant #3: "A"

"There is only one true authority in that room and that's me"

Sitting with "A" for this interview was the first time I saw, reflected back at me, my owninternal, private anger over the treatment and lack of answers I'd received from the healthcare system. I think the opportunity to have this conversation with "A" ended up being cathartic for us both, and for that I am so grateful. At the end she let me know that her expectation was to leave feeling drained and down, but that her experience has been just the opposite. During the introduction portion of our interview, when I asked about her reaction to the call-out for participants I was met with an enthusiastic *"fuck yeah!"*. It was clear from the beginning that notonly did "A" have the same communication style as me, but she also had a tremendous drive for advocacy, for herself, for others within the fat community, and for fat acceptance work.

> *Fat Liberation is so important. And it's something that fascinates me and is obviously very close to me in my heart and my life as a fat person and um. That it [this project] waslocal, that was like yay! And um, talking about healthcare in particular. That's somethingthat I've had to deal with my entire life. And anything that could potentially help or support other people in the fat community and people who are working for them to bettertraverse the complexities of dealing with health and destigmatizing and undoing all of theharmful systematic issues. Yeah! Okay! Please do that! That'd be great!*

"A"'s story also began as a young, fat person, when her hormonal differences were conflated with her size, and ignored as a result. She pointed to a failure on the part of doctors to recognize the biases and learned discrimination within medical education and training. "*You could write so much about doctors not believing women's pain...and especially not believe in fat people's pain.and I mean, oh...It just boggles my mind...It's something that is known, is actually quantifiable. The actual studies in science shows that doctors, and doctors as a whole, not just the white cis males, but doctors, medical* *professionals, somehow, they go in as humans and they come out of med school as disbelievers"*. "A" shared with me the mental anguish that came from fighting forand finally seeing her medical files, where she had been mislabeled, misunderstood and completely dismissed by the very people who were meant to help her through her healthcare challenges. For "A", her file stated very plainly: "*you're doing this to yourself, it's all in your head, you're just looking for attention, it's not real. Ah...and the tests results are inconclusive so there's nothing wrong with you...Get out*". Having given up and reduced to living *"in a broken body"* something eventually got her back riding *"the advocacy train"*. But answers didn't come easily, "*it it…it was a process… The diagnoses didn't come all at once, it was very much a little little little trickle…And then having to…Basically getting like puzzle pieces from every doctor and every specialist and then trying to piece it all together [myself]".* "A" pointed to holism as amissing factor in her healthcare experiences. "*I find one of the challenges, especially when you don't have one single caregiver, is that its disjointed and not holistic. I find that it is a [emphasis] real real challenge when the missing piece of holistic healthcare is missed".* This disjointedness often resulted in minimal options or the centering of "A's" weight in her healthcare plan. "*Doctors like to treat the symptoms. And not the actual underlying cause. And I'm sure that any fat person that has ever had dealings with doctors, they treat being fat as a symptom"*. The ability to press on despite mounting challenges pointed to "A" persistent self-education and self-defined "*ownership of my own health*". To me, it seemed these were her fuel for motivation and drive around personal and community advocacy. *"...And having to do a lot ofresearch for myself. I think fat folks are like the royalty of online research, for medical diagnosis, medical treatment, and really really believe in self-diagnosis. I really*

really believe inself-diagnosis. Because the system we live in means that that's all we have. Right?". "A" told mestories about her force and sheer determination within healthcare spaces, acknowledging the dangers of being ignored but refusing to go unheard.

> *Basically [I] took ownership of my own health…I would go in and say 'these are my symptoms; these are the tests I need…these are the meds I need. I need a follow up and I need a… referral… I need this form and have a great day'… That's basically the best thing that's come out of this…You just get used to being dubbed the hysterical woman. The angry woman. The aggressive women…It's either that or I die, and I'm not into thattoday.*

Having lived throughout British Columbia and with health concerns that necessitated early entrance into medical spaces, "A" recognized the shortage of doctors as having contributed to alowered quality in care but also a growing gap in services. "*…And the thing is that they've created a system where those are our options. Because if you do find even a slightly open- minded doctor, they aren't taking patients*".

"A's" recommendations for the future include fat liberation in the form of fat inclusion in healthresearch, elimination of BMI and diet culture and the harmful "*if you just lost a few pounds' fallacy*". "A's" fat future recognizes all intersects of identity, is free from patriarchal influence, embraces medical consent culture in practice and addresses societies part in the perpetuation of fatphobia.

> *Taking it full circle back, to the whole taking care of your body, there's this nastiness thatsociety seems to have about thinking about fat bodies…That its gross, or that it's like, ugly, or 'ew', or off putting. All those things that society tells us they feel about our bodies, and then we have to internalize the feelings of whatever-shame or self-loathing orwhatever it is… We take that on, about our own bodies, you know? And it's like, very courageous to talk about it, and take that power away. And to reclaim it. And to be like "no actually. This is something that everyone deals with". And it's just something that ourbodies do.*

Participant #4: "M"

"*A year later, I'm still internalizing that an ER doctor called me obese*"

The fourth interview, with a participant known as "M", was done somewhat differently from the first three interviews. Due to COVID-19 restrictions at the time of this project and my unwillingness to exclude participants who were unable to meet face to face, "M" and I ended up,instead, having an almost two-hour phone call. We spoke at length, while I imagined what she described as pacing around her courtyard confines, earbuds in place. During this time, "M" offered anecdotes and first-person experiences of facing fatphobia both in and outside of healthcare. As a person who identifies as fat, she also identifies as an ally for those in her life, including parents and friends, who are on the fat spectrum. "M's" descriptions of these events indicated a process of ongoing learning and growth, one that has unearthed personal intersects of privilege and contributed to her own fat acceptance. During our conversation, she recounted her participation in online fat liberation spaces and the resulting discoveries.

> *Things that I had never considered or [had] written off… I found it sort of comforting and also eye opening… I think the eye opening came from like a couple struggles. And seeing that they're universal for [many] of size. Things like that where I'm like, 'wait, amI just sort of struggling with this [just] because it's me or…?' And kind of seeing that there's others? That was really nice. Yeah.*

Instead of being left wondering if her struggles were unique to her and her body, the online spaces helped "M" arrive at new, eye-opening perspectives and increased understanding for the unique struggles of different communities within fat spaces. M's broad perspective also seemed to grow from a self-described diverse working history and multiple opportunities to demonstrate allyship within a variety of sectors. One opportunity to "*stand up*" for size acceptance came while considering the complex needs of individuals with differing abilities whowould be participating in or helping organize a series of events hosted by “M’s” employer. T-shirts were to be ordered and distributed to staff and volunteers prior to, and “M” details herexperience.

> *They're fantastic…A really great organization… But [often] with intellectual disabilities, comes a physical component… So, there are people of all sizes with severe intellectual disabilities [participating]. However, t-shirts sizes… only have up to a women's XL, which is not very large… It’s actually narrow… But you should give the option of ordering in a larger size. You have athletes that you order these sizes for, why not for your volunteers as well? And the thing is… I have worked these events with people that are wearing instead a vest or a, you know, a sash or something because they don't haveshirts in that size. And I'm like, ‘is this the way that you've handled that, that you don't see something past an XL? So, ‘ok, here's a sash’. Because that’s ridiculous. People arevolunteering their time and their space. And you should offer them a shirt that fits.*

These seemingly small advocacies did not go unnoticed for others needing larger sizesand contributed to “just opening one person’s eyes. Widening one person’s lens, then you’re doing good work”.

Discussions of good work brought us to notions of “*good care*”, and “M” located those by way of “*finding a good doctor…finding a good clinic… [also finding] multiple communities as part of health care*” which she believes is part of the ideal healthcare experience. Communitywas also raised here as being an important piece of the “*good health care*” puzzle.

> *Yes. Finding a good doctor, but also finding a good clinic…because even when I found agood doctor, the nurses every time ‘you trying to lose weight? You trying to lose some kilos?’. It’s been…a unique experience of finding just community in whatever way. It doesn't necessarily mean commiserating. I am happy to go to yoga with yoga people whojust talk about yoga. And that's why I feel like I found multiple communities as part of health care… I found a community where I can discuss weight or weight related issues.But also, one where we just don't talk about it at all. So, it's not even that it's Like the yoga studio situation. It's not fat positive or not, It's just yoga.*

Through "M's" experience as the daughter of a fat parent, as a wife and as an ally, she has facednumerous challenges, often presented by other fat women, while seeking care and community. The patriarchal influences women face in healthcare are substantive, especially when it comes to reproductive health. Instead of being supported in her attempts to improve her reproductivehealth, doctors pointed to her weight and leaned on her marital status.

> *[Emphasis] Any, any issues you're having could be made better by losing weight…And so, he's like [doctor]... 'What you can do, what you should do is, you should put a print picture off of when you used to be smaller and put it on your fridge.' I'm like again, 'can we please talk about my uterus? And then…Basically, he said, 'I understand that you want to potentially look at getting a full hysterectomy, but I'm going to need your husband's permission'.*

After "*literally walking out the door*" and moving to a different province, "M" had the chance totry again with a different doctor but explained "*this was before I had my community of people here. And you know, I was actually very nervous because of my last doctor experience… The oneI walked out of, about the hysterectomy. And so, I'm like, 'oh, crap'"*. "M" describes the first time meeting her:

> *So, I'm kind of like swallowing, right? Like, heavy swallowing, like, "oh, God, I don't want to go through this and have her say something". And so, I got on the chair and she looks at me and she's like, 'what's wrong?' And I was like, "nothing." And she was like, 'do you think I'm going to say something about your weight?' And I was like, 'honestly, yes.' And she said, 'you know what? I don't care' She's like 'let's get you sleeping better.*

It seemed perhaps this time, "M" had "*found a good doctor*". Despite establishing good primary care and community support in a new province, "M" still comes up against emergent situations that thrust her again into confrontation with internal and external biases. Those who have not experienced being fat cannot comprehend that reality nor the implications of accessing healthcare and part of "M"'s role has been helping those in her life both better understand this reality and learn how to support people like her.

Another area of support “M” brings to fat acceptance, that can be a challenge for manywho engage in this work, is weight/identity fluctuation and shifting forms of allyship.

> *I think part of allyship [is] like my weight may change over the years. It's normal, right?... And I think the important thing that I'm learning from this as well is how important allyship is, regardless of my own situation… You know, you can be a triathlete and now you're an ally for saying, ‘no, overweight people deserve just as much medicalaccess as I do’.*

“M” spreads this information amongst her friends and family, in professional and volunteer rolesand in her classrooms at school, determined to have the messages of fat acceptance and diversityof experience heard and integrated into all areas of living. The time “M” and I spent together leaves me thinking about how we can build consideration for all types of bodies who are attempting to navigate spaces general society tends to take for granted.

> *Well, what do you think? Fat people don’t scuba dive?... That [someone] could afford anextra thousand-dollar seat…first class…because those are bigger seats… And so many…issues around weight [and body] related concerns with weddings… I had a groom in a wheelchair one time, and the honeymoon suite that they were staying in had two stairs upto a bathtub like, you know, fancy hotel room. So, I was like, ‘oh, um, do you have a honeymoon suite that doesn't have stairs?’ Right? And the person at the front desk said, ‘I just didn't think people in wheelchairs got married’.*

Researcher Becomes the Researched

Moving through this unique process and experience of writing a thesis, I got blocked forsome time as I understand many students do. I believe much of this came from parallel efforts I was making to process very personal, internalized fatphobia while facing it head on through thisthesis work and experiences within local healthcare systems.

> *During the middle of this thesis…my health declined [again] and because of the circumstances…my alive and well, outdated, fatphobic belief system kicked in. And I gavein. I gave up. I finally believed everything I had been told, at least about me and my fat body. The part of me that just kind of gave up suddenly thought maybe all these things that I've been fighting against and pushing against and learning about, they are wrong, because here I am, this living, breathing, fat body who has all these perceived fat disorders*.

I started to believe that I alone must have caused what was happening to my body. That every anti-fat narrative I had spent the last year working to dismantle and untangle, was true. I attributed my failure to my fatness, and I gave up. I even reached the point that I stopped taking the medications prescribed to me for an under active thyroid and an overactive heart. I got fatter.I got depressed. Being told I have a heart problem when I have existed in a fat body for years seemed like the end of my fight. Being told I have a heart problem because of my lifestyle, regardless of how many steps I walked or how much kale I consumed, seemed like the end of theline. How could I argue or reason with a heart problem? I've heard the heart and stroke statistics; seen the campaigns and I had even been personally touched by the outcomes. At forty-two, just seven years older than I am now, my biological mother passed away from a massive stroke, something I am reminded of by myself and others, often.

During this period of decline, I lost my desire and drive, my passion. I wondered how Iwould face the participants when my own body had betrayed me and continued to betray the messaging of our communities. How would I face the multitude of critics who were growing innumbers each day? How would I complete this process?

I can't quite say what specifically it was that changed or how it had come to change, but it was unexpected. Perhaps it was my inherent stubbornness that was kicking back in. Or the anger I was still holding onto, the rage. Nevertheless, connecting a passing thought to a passingmoment, I was able to recognize a connection. I had 'irresponsibly ignored' doctor prescribed medications and with that came a disappearance of symptoms. The absence of symptoms allowed for the suspension of self-blame, just for a moment, and from there I began again. I found a doctor who listened, said it was okay to stay off the medications and worked *with* me to start over. She saw what I did, that eliminating a prescription had also eliminated the heart symptoms. This was a turning point for my health but was also the moment I stopped separatingwho I was from this work and began finding a way back in. I returned to the *Fat Bodies in Space*project, my journals, the literature and the participants stories and searched for a way to include my own voice. The following section reflects that voice, parts of my story and the experiences and trauma's I have survived in order to build this project.

Participant #5 "Katie"

I have always disliked 'going to the doctors', have felt an immediate distrust for most practitioners I've encountered, and I can't remember a time that I didn't feel that way. Throughout my childhood I can recall numerous appointments for excruciating stomach issues,allergic reactions and other ailments or pains that either went unexplained or were diagnosed asstress.

> *I have never really been able to understand how stress could produce such…pain. I thinkit probably started for me when I was as a kid, being*

> *told 'this is just stress'… Having a very real issue… and being told it was just stress…I think those labels really created something in me about how I came to interact in these healthcare spaces. I guess as I got older it developed into this idea of like, not being believed, right?... If I go, the doctor is going to label it stress. I think it took me a lot of years to ask the question, 'why doesn't anybody notice a child has this much stress? And why doesn't that matter?'.*

As I got older, doctors would dismiss my concerns outright or point toward my fatness asexplanation for any issue. On a couple of trips to the emergency room I was refused treatment and questioned at length about the alcohol and drugs most certainly contributing to the presenting problem. One of those times I was in my early twenties and living in Ontario. A friend brought me to the hospital after I'd failed to look up from my phone and fallen down several stairs leaving the gym. I spent hours in the hospital hallway, nurses repeatedly asking how much I'd had to drink and which bar I had attended all while refusing to treat my pain. I remember asking them to look at my clothing, as if my sneakers and sweatpants would somehowprove I hadn't been drinking. It was later discovered the fall had caused a complete tear in the ligaments of my ankle and the injury took over a year and a half to heal even adequately.

Immersion in a medical system that only saw my body as a problem and dismissal in theface of suffering gave way to loneliness. No one else in my family was fat. No one else had described having these problems and none seemed bothered by visits to the doctor. Moving to another province where I no longer had primary care providers only increased avoidance, as I refused to access regular screenings or testing, only seeing a doctor when it became absolutely necessary. Unfortunately, I couldn't avoid doctors or my health forever.

> *So, I think that's how it came to be for me, where my health care story [as an adult] didn't include health care professionals. I did everything at home*

> *I could. I learned how to take care of things. But eventually there came a point where I had to kind of admit defeat... about three years ago. I cut my hand with a knife in the kitchen while cutting anavocado and I'm like, 'ok... I don't need to go to the hospital for this. I don't need to bother anybody'. You just stop the bleeding, and you deal with it. But it wouldn't heal. And so that was one of the first times that I kind of had to be like, 'I have to do this. Ihave to make myself go seek health care treatment'.*

My battle with the avocado and resulting wound forced me to again face the healthcare system.When my hand wouldn't heal, and the messages of dismissal and blame began, I got angry. "*I know my body. I know when something isn't right".* I couldn't understand why the doctors wouldn't listen to me.

> *I almost felt punished for opening my mouth and not being a slab of meat. It's like, 'well, we have to do this and if you don't want it, then leave'. But I'm still a human being that needs this service or needs this test or... still need [you] to work with me. And I've definitely gone through that they've done a million of these [tests/procedures] and I'm just one person coming in and being like, 'I'd really like it if you...' or 'could you just...?'And I get that that's annoying. But this is where I think I rotate back to ego...You cannot have ego when you're dealing with other people's bodies. They're not disposable. They're not just flesh and meat. They're a human being with feelings and histories and traumas. And I think it's better to look at every person that walks through the door as somebody with all of those things, even if they're the easiest patient in the world, because you justnever know.*

During the final semester of coursework for the Master of Social Work program, I found myself again waiting in a doctor's office for more tests results. I sat with heavy anger, already blaming the physician who was about to enter the room and make assumptions about my body ordiet. Trying to keep calm, I scanned the room: exam table, instruments, computer, pamphlets, calendar, signage. One sign stood out so much so that I took a picture of it. The sign reminded "patients please note, only one issue per visit" (Appendix C). "*That picture of that sign...it represents how this [thesis] all started".* I was initially irritated, thoughts of the sign stuck with me that week. I wondered who made up this rule and why, thinking of all the obvious barriers inflicted by eight words and simplicity.

> *And we can't do that because we're not one issue. More a complex like, mosaic of things.I think that speaks loudly to health…We try to extract these individual elements of the human experience or the human condition. What do we end up with but this fractured, you know, quote unquote treatment plan or fracturing of the individual themselves? Because as somebody with multiple intersections or multiple identities, I feel you can only hold one or even a part of one in that tiny doctor's office.*

I realized "*I had to get out from under my anger about doctors*" and used the final research assignment for my degree program to better understand the layers of North American medical systems.

> *I guess in a lot of ways… I started this project [because]I had to stop pointing the finger at doctors… I expect this doctor to meet all of these expectations that I have about what medical service looks like. And when I finally stepped back from that precipice of anger, Icould see the systemic issues… the history… the confines that they're working within. Andthey're just another human in a system trying to work it out to, to pay for their life and their family or whatever it is. And they're confined by all of these things that are put in place by policy and the systemic crap that's happening.*

Over time, even as my circle of support expanded, it was difficult to find others who understood what it was like to be fat accessing healthcare and what those experiences can takefrom you. Online communities created by fat individuals became crucial as I scrambled for options and ways to manage the ongoing medical encounters. Within these groups I found support along with entirely new perspectives on what it meant and didn't mean to be fat.

> *I think in a lot of ways it's about that validation. Like, when you're in a doctor's office, you're alone. And even when they come into the room, you're still alone. And being able to find that space…where everybody was sort of sharing that aloneness, it was massive validation for me. People speaking back to it and sharing with other's how they did that, because a lot of us weren't in a place where we were ready to do any of it. And folks werethere carving that path for us, showing us like, 'this is what I did. This is what I brought with me. This is what I said. And here you can do it, too. And we're all here waiting for you to come back and tell us about it'. And*

> *that was just like, [exhaled] massive.*

The online community and resources they shared created a network for people like me to explorealternative narratives about our bodies and unpack outdated belief systems imposed upon us during our upbringings. "*When I was hurt or sick, I wasn't believed. Which I think is true for a lot of people, especially whose parents are my age. You know, that 'grin and bear it' or 'pull up your socks' or 'you're fine'. You go on anyway".* I found that these old ways of thinking had informed my previous interaction with healthcare providers suppressing my ability to self- advocate. Self-advocacy was not easy and took up a lot of time and energy. Much of the early work I did was around learning to be 'okay enough' in medical spaces and relearning how to trust myself and my body. None of this work, personally or for the completion of this thesis, would have been possible without these online spaces and the project participants with their fourstrong and loud voices. Leaning into their stories of strength and advocacy when I needed it mosttook me across the finish line of this thesis work and encouraged me during some of the darkest points yet on this consuming and lengthy medical journey.

The advancements I've made both physically and emotionally would also not be possiblewithout the three small, but powerful words I fought so hard to hear: "you have [insert diagnosis here]". These words strung together formed *my* diagnoses, which, turns out, are not a result of my weight. Receiving a diagnosis does not in any way signify an ending, at least not in my story,only a beginning and an opportunity to regain control of my health and my body again. There is a power in diagnosis that works to benefit not just the patient, but the people in their lives who support them. I speak for myself when I say, being able to look outside of my fatness and being seen as a whole person has only allowed me to fight harder for my health.

The results speak for themselves: Though I still have a thyroid condition, it's no longer problematic. The heart condition I had supposedly developed disappeared and was found to be caused by too much of the wrong medication. My test results and day to day issues have improved and my blood sugar as always, remains awesome. Am I a doctor? No. Have I lived andcared for this body for 36 years? Yes. I am still fat? Absolutely.

The journey has been long and hard but the opportunity to tell my story and hear the stories of others has been incredibly meaningful and this experience will continue to guide my efforts in the future, both professionally and personally.

> *Reading these…stories and reading about struggles [online] and seeing how many people are having these conversations about health in this capacity… I kept looking because it was my experience, too, and being around a bunch of people that share that was pertinent for me. It wasn't until later on I think that I realized that fat was part of that[discrimination]… I mean, maybe we take that for granted or maybe it's just because we're so conditioned, you know? Yeah, of course, I'm supposed to diet and of course, I'm supposed to lose 50 pounds. But no, fuck that. It's… I kind of am living, breathing embodiment of fuck that. Because I'm still fat and I don't have a heart condition and I almost don't have a thyroid condition. I might have "conditions" or "diagnoses",* [emphasis] And, *I'm a fucking healthy person. So, as you know, this might not be the most robust study, but for me it was.*

My story continues as I look for answers and find new ways to advocate for my health. Istill spend a lot of time in waiting rooms and blood labs but, as a result, I've been able to watch the system change in small ways. I've watched doctor's and practitioners shift, some acknowledging the gaps in their field of work and taking real steps to fill them. I've felt the shared humanity again, I've been part of collaboration, when both patient and doctor are able toset aside ego and replace with solutions. I've experienced the difference fat acceptance in healthcare can make and it has only served to engage me again with the medical system, encouraged preventative and wholistic treatment and allowed me to take care of my body and my health.

Chapter 5: ANALYSIS

The first intention of analysis processes in qualitative research is to consider the collected data alongside the knowledge gathered through scaffolding the growing literature and research (Thorne, 2009). In this case, data collected refers to participant stories and the intention of analysis is to locate similarities, differences or emergent themes. The following chapter is divided between two sections, analysis process and themes. The first section will describe how thematic and narrative methods of analysis were applied to both the development of participant stories from chapter 4 and the themes that will be discussed within chapter 5. The second section explores in more detail each main theme and successive subthemes that emerged through the process.

Analysis Process

Following the completion and transcription of the four main interviews, a manual processof narrative and thematic analysis was initiated. The way I've come to take up analysis is in three stages. The first stage involves reading and familiarity with the participant's text and 'voice'.

The analysis work of Cree/Métis researcher Dr. Lisa Borque-Bearskin (2019) informs this stage, suggesting first readings view a transcript more as a whole in order to gain familiarity with a participant, the tones and other elements of text. During the second read, Borque-Bearskin (2019) recommends a more in-depth approach, looking at phrases and terms that appeared significant or captured the participants point of view in meaningful ways. The third reading examined the documents sentence by sentence, highlighting statements, topics or ideas that may appear to have significant meaning or hold commonality throughout other interviews. Reading the transcripts together in this way provided an opportunity to build upon connections and ideas within and across the conversations. Throughout, I maintained separate notes, journaled ideas, questions and feelings that surfaced while completing the readings and logged prominent or repetitious phrases and words used during the stories. I used charts to track poignant quotes and as a way to view participant ideas, visually, across all of the interviews. The consistency of this note taking, journaling and charting practice would go on to be integral in the theming, analyzingand writing processes.

Theming Stories

The analysis process yielded some major themes and expanded on previous insights brought forward by the fat and academic communities. At minimum, these themes demonstrate the overall importance of diverse and intersectional fat narratives in social and healthcare spaces as well as some of the harms and impacts currently felt by the fat community within Victoria, B.C. The following developed themes are discussed: *Fat Consciousness*, *Fatphobia & Diagnosis, Compounding Disbelief, Unintended Consequences and Reimaging Care & Self-Advocacy in Healthcare.*

Theme: Fat Consciousness

Fat Consciousness stands in contrast to other notions of weight consciousness. In some narratives weight consciousness describes how one's journey to the perfect weight supposedly occurs through a process of mindful self-love, and in others, weight consciousness contributes to growing concern, awareness and avoidance of increasing weight. Fat consciousness in this context references the ongoing self-conscious discovery or awareness of one's fatness, external fat stigma and subsequent decision-making processes following that discovery. In their stories, participants came to consciously know, understand and interact with fat identity and eventual fatphobia or stigma through ongoing social, familial and medical experiences

> *And I would think in my head. Well, they're just giving up. their just being lazy. their just...like all these messages that I received, through my childhood as I tried to lose weight. I've had self-awareness and shame of my fatness since my 5th birthday. I have a first memory on my 5th birthday weighting myself and whispering to my mum how much I weighed.*

It was found within this collected body of stories and research that pathologization of fat(ness) contributed to the acceptable distribution of fatphobia in medical care and broader society. Participants carried these early learnings through every stage of life, coming to believethat fatphobia and anti-fatness were part of the 'norm' and the medical experience. *"[I'm] an 8or 9 10-year-old, and doctors just told my parents 'well she just needs to lose weight and exercise.' And that was pretty much the beginning of my introduction to western medicine and western doctors saying 'oh, you're just fat sweetie, that's all'.*

Bodies shift and change over time just as one's realizations or feelings about their body, fatness or what it means can develop and change in relation to context and experience. 'Obesity' and medical perceptions of fatness seem to remain unchanged. One participant, who has lived at many weights, describes "*this omnipresent thing…just still there*", that was left behind after one of her first experiences of fat stigma in health care. Something remained with her after being charted as 'obese' during an Emergency room visit for stitches in her finger. Participants described shifts in perception of fatness during health care experiences. These shifts were marked by negative and traumatic experiences at the hand of health care providers and systems, but also through finding positive, meaningful interactions with practitioners. The broad spectrum of fat consciousness was experienced by these participants from the individualized point of views held during their younger years, to their individual understandings of fatness, (anti)fat stigma and eventually fat acceptance.

Theme: Fatphobia & Diagnosis

Among the participants, there was a shared experience of the immediate centering of their'obesity' across a variety of medical spaces and practices and discussed the blatant and seemingly connected, acceptability of fatphobia within. Participant experiences offer examples of how 'obesity' and fatphobia have come to define much of the dominant social and healthcare standards or belief systems. Both of which are not only dictating the inappropriate treatment fat individuals continue to receive but also, the treatment many have become forced to live with.

The third participant described seeking treatment for a chronic condition well documented for intersections with fatness. Patients who are categorized as obese have struggled to be seen by practitioners outside of their fatness. This lack of recognition for the whole patient and their history indicates fat as diagnosis, perpetuating the conflation of health and body size. As a result,many conditions went untreated for these individuals due to conflation of health and size leavingmany participants feeling ignored or dismissed. Practitioners' singular perspective of 'obesity' has contributed to the way doctors dismiss these and other fat patients contributing to the damageuntreated issues or lack of prevention have on health. Individuals seeking real help for issues thatgo on to have great impact on wellbeing hear many messages, like the one above: *'oh, you're justfat sweetie, that's all'.*

Medical models as a result have become reliant on *fat as a diagnosis* and participants hadto consistently and sometimes aggressively advocate to be taken seriously or in order to receive more than just weight loss and dieting advice. This issue of diagnosing as fat created further barriers for those with intersecting identities, whose mental health or gender affirming needs go unmet and overlooked because of BMI.

Theme: Compounding Disbelief

Pathologization of fatness and centering obesity in fat patients' care spurred disbelief andoften led to perceived mistreatment via unwelcome or harmful comments, assumptions, stereotyping. Participants experiences of mistreatment left many "*feeling invisible*", receiving incorrect care/treatment or denial of treatment entirely. The stories indicate that the *disbelief* of doctors has had major implications on participants' health, mental health and their personal health outcomes. These effects are significant for those whose fatness existed alongside other intersections of identity ("*racialization", "female-presenting", "trans", "disabled*").

> *I feel like... You could write so much about doctors not believing women's pain...and especially not believing in fat people's pain. And I mean, oh... It just boggles my mind. So, I had to fight really hard… Dealing with a bunch of medical and physical things. And I was going through… debilitating pain. And not knowing why and having to deal with walk in clinics and specialists and referrals and being dismissed and not believed, and the [primary] doctor was not helpful, not supportive and not believing.*

Participants struggled to find practitioners who saw them as a whole person, not as a list of 'obesity' risk factors and opportunities to recommend weight loss surgery or the latest fad diet. Each person who participated in this study, especially female identifying members, talked about experiences of not being taken seriously from a young age, either because of, or in spite of their weight. In one participant's case, *disbelief* of her pain and symptoms began at the onset of pubertyand lasted well into her late teens. Her situation became so extreme that she eventually required ablood transfusion, and only then was she taken seriously.

Doctors in the stories continued to look for ‘weight-related ailments’ and attribute medical issues to their fatness without considering another cause. Nearly every participant reported being tested repeatedly for diabetes, thyroid conditions, cholesterol, blood sugar, despiteno evidence to support these concerns other than “above average weight”. *“Oh, if I had a dollar for every time, I had had blood work done to make sure I wasn't diabetic, didn't have thyroid problems, that my cholesterol was still more or less okay...And its always okay... It’s always beenokay!*”.

> *Every single doctor I ever get blood tests from has to go back to whether my thyroid is dysfunctional, and I tell them… ‘my thyroids fine, it’s always been fine…my* Cholesterol'*sgood! It's always been good.’ But it gets tested again and again because I'm not believed and because it’s assigned to me that I must have these conditions because I'm fat*”.

Disbelief extended beyond the doctor-patient experience, and the treatment being offeredor withheld. There is a major impact on the patient themselves, their supporters and family members who are looking to the professionals for answers. Not being believed has been seen in this study to have an effect on mental health, self-worth and esteem. Not having the support of professionals or loved ones only furthers the effects of whatever health challenge is going unaddressed.

Theme: Unintended Consequences

As a result of weight being centered in most medical situations, many participants hadn’tseen doctors as someone they could go to with their concerns contributing to avoidant feelings and behaviors. Negative encounters and a focus around weight while seeking care continued tobuild over time prompting one participant to often take more extreme measures to avoid a clinicor hospital, “*including removing my own stitches”* (personal communication, July 28, 2020). Others, when faced with serious injuries, didn't want to seek treatment because of past experience and either didn't go or had to be encouraged or convinced by a loved one.

Weight loss is found to be more often centered during the medical interaction despite thedetriment to other aspects of one's health. The stories and research reflect that 'obese' patients are often encouraged to maintain poor eating habits [starvation], remain on conflicting treatments or accept negative side effects, all in support of weight loss. Fatphobia has become largely acceptable in medical spaces where comments are made about fat bodies that would not be acceptable of a 'slim' body. Acceptability and perpetuation of fatphobia in medical spaces has been found, in this study and others, to impede preventative care and increase patient avoidance (Drury & Louis, 2004). In order to provide care, medical spaces must sometimes ask that patients, who are already experiencing fear or anxiety, be in highly vulnerable positions, as with a necessary screening or procedure. In one participant's case, it was a mammogram. *"I once had a mammogram that had ashadow and so I had to go get an ultrasound and the... And the practitioner looked at me and said, "How am I going to find anything in* those *breasts?" And there I am... like on my edge" (Leslie, 2020).* The guilt, shame or embarrassment grown out of a moment of fat shaming or fatphobic rhetoric might ensure the patient never returns and a lump or spot goes unexamined.

Subtheme: Disordered Eating

Shame and pathologization have major implications for mental and emotional wellbeing.A focus on weight often overlooks a multitude of treatable concerns and, as a result, participantsreported discomfort in sharing the full truth with their doctors. Labelled a subtheme, *disordered eating*, was one example of how participants seemed to internalize socially and medically imposed narratives about bodies, be it perfect or average body ideals, fatphobic rhetoric, pathologizing and obesity-centered narratives or otherwise.

The stories depicted struggles of living with but never addressing disordered eating, leastof all with a doctor. "*In terms of disordered eating stuff, I've never really brought that up with a medical professional".* Participants shared doctors "triggered", "dismissed" or "congratulated" them when it came to admitting to an eating disorder or that their weight loss had not occurred ina healthy way. When telling of disordered eating, participants made meaning out of past experiences by building connections between what they had been through, in their childhood as one example, and their disordered eating patterns. The narratives reflected an undeniable relationship between how society views and treats fatness and fat bodies and the ways fat bodies and those around them, come to see and treat themselves and each other. Those who had lost weight in "*unhealthy ways*" discussed the feelings and attitudes they encountered and the realization that "*health and thinness [conflate] within the medical profession. It's there from the very beginning*". In the face of this reality, many of the participants at one time or another, felt they were left without options for their health. Despite anti-fatness playing a consistent role in allfive participants medical journey, there was also a unanimous and (nearly) unwavering narrative of self-advocacy. These individuals recognized along their process of fat consciousness and self-discovery, that unequitable and discriminatory treatment in their healthcare was not only unacceptable, but it was also dangerous. Finding fat acceptance and learning how to self-advocate was their way of offsetting that danger.

> *…The thing that worked the best for me was stopping caring about the doctors…about what they thought. And basically, took ownership of my*

> *own health… I would go in and say, 'these are my symptoms, these are the tests I need…these are the meds I need. I needa follow up…I need a specialist referral…I need this form and this form. And have a great day'. And when they looked at me all snotty, I just stared them down…You don't doyour job; I'll do it for you… You're not going to do this? I'm not going to die in front of you because I'm fat, you fucker. That's basically the best thing that's come out of this.*

Theme: Reimaging Care & Self-Advocacy in Healthcare

Through the participants suggestions and concerns, the theme *reimagining care* was formed and points to two approaches. The first approach shifts how practitioners understand andattend to *"the care piece"* of medical practice and education. "*They've taken the care piece out of medical... It's no longer 'care', its diagnostic and treatment. And I feel that...Every human, fator otherwise, suffers because of that*". Participants indicated human centered care in medical practice must be prioritized in order to offset harm and patient avoidance. According to the participants, achieving human centered "good care" often rested on the notion of "a good doctor". The "good doctor" achieved this role by listening with respect, considering history, the whole person and centering weight differently in their office space and practice. Examples included asking the patient questions before assuming, being believed or validated by the practitioner, non-fat-shaming office literature and posters, attention to personal comforts and body differences. The tone of signage and pamphlets, size of gowns and sheets, availability of large blood pressure cuffs, were all indicative of a "good doctor", the type of physician who wouldn't generalize and gave enough time to better understand them as a whole patient.

Participants valued patient centered care through conversation instead of instruction. Being directive was sometimes seen as doctor's attempt to save time, but participants indicated that direction or medical advice out of context left them feeling unheard, without help or forced toexplain themselves, which just prompted disbelief or feeling of not being believed.

The second approach to *reimagining care* was to build upon care as a co-operative and wholistic effort, seeing that “good doctors” take contextual and collaborative approaches to theirpractice and patients. It was indicated that physicians must critically consider their own biases and values but also those of the patient and how they have come to understand their own health and body. Further, good care is necessitated by transparency, consent, the support of patient autonomy and focusing on what’s important, specifically what is important to the patient.

Medical school education was discussed in this context, suggesting changes must be made tomedical curriculum. Inclusion of a broader range of courses or perspectives when training tobecome a doctor was suggested along with centering those who have lived experience in the production of knowledge, policy and practice.

> *The whole training for doctors. I mean…they’re trained into their rigid beliefs. And theirbiases AND to do any kind of research or investigation or training about fatness without the engagement and authority of fat people is not...is just going to result in bad medicine.It’s that "nothing about us without us". How could you possibly know about us without finding out from us, and without recognizing and respecting our wisdom, our experientialknowledge*?

Chapter Six:
DISCUSSION

For these participants and others living on Vancouver Island, choice of care providers was rarely an option. This part of the west coast is currently experiencing a “doctor shortage” (Dolor, 2020) and despite the perception of Canada’s free healthcare, it takes time and money to have your health needs met. It is estimated that close to seventeen thousand people on Vancouver Island live without a consistent primary care provider (Vancouver Island News, 2020), forcing many seeking care to contend with “the longest wait times for walk-in clinics across the country”(Chan, 2019). Although millions of dollars from the present B.C government are attempting to fill this gap (Vancouver Island News, 2020), it does nothing for the systemic discrimination faced by marginalized and fat individuals working their way through the healthcare system.

No one sits in the role of expert better than the patient themselves, fat patients included. While trans-disciplinary praxis and collaborative care aim to create more cohesive and wholistic approaches to healthcare in order to improve patient outcomes (The Canadian Medical Protective Association, 2007), they fail to properly center the patient as the expert in both diagnosis and treatment. Individual health care seekers are under resourced and falling between the gaps in the system. Social workers and adjacent professions may be uniquely positioned to play such a role in addressing these serious gaps.

Introduction

At the beginning stages of this study, I believed that achieving good healthcare meant moving away from the medical model towards wholistic and patient centered care. Though in some waysthis is still true, the participants, my personal healthcare journey and this thesis process have validated the need for steps beyond patient centered care. Patient centered care aims to individualize medicine, include patients and their families as members of the care team and encourage two-way communication and collaboration between physicians and patients (NEJM Catalyst, 2017). However, it has been found that simply implementing this model does little to address how practitioners are educated or how care systems are designed and managed. Studiesexamining the outcomes of patient centered care indicate that physicians often lack financial incentive and the time required to implement the models appropriately; revenue is lost as less patients are able to be seen (Budgen & Cantiello, 2017).

Working Towards a Socially Just Model of Care

Since inception in the late 1800's and throughout early development, social work practicehas maintained a steady focus on individual and social issues such as poverty, child and family welfare and domestic violence. The social justice underpinnings of modern social work have allowed the profession to broaden, taking on a more critical and intersectional approach to practice. "The term critical social work refers to theory and practice which assumes that economic, cultural and social structures privilege some and not others" (Rossiter, 1996, p. 23). Social workers have become uniquely situated in North American communities to dismantle oppressive systems and advocate for those whose bodies or identities have been or are currentlybeing marginalized.

Social work has expanded to include praxis in correctional institutions, school systems, health care spaces, Indigenous communities, the armed forces, treatment and rehabilitation centers, clinical practice and many other fields. Despite the broadening scope, for many social workers "activism never included fat bodies" (Cooper Stoll, 2019,

p. 422). Much like the medical field, social work has demonstrated a failure to critically engage with fatness as a marginalized identity because it is typically viewed through the lens of 'choice' or as a demonstration of 'bad choice' (Cooper Stoll, 2019; McHugh & Kasardo, 2012; Puhl & Heuer, 2012; Sender & Sullivan, 2008). The 'eat less-exercise more' myth sustains within many sectors,social work included, and is supported by the 'obesity as disease' and 'war on obesity' narratives. Through research, policy, and practice, the war on 'obesity' has developed into a waragainst fat people (Cooper Stoll, 2019). In this way, fatness has also fundamentally become "a social justice issue that continues to intersect with other systems of inequality like gender, race and class in very problematic ways" (Cooper Stoll, 2019, p. 12). Social work theory and practicehas demonstrated that systems of oppression work in tandem to both produce and reproduce injustices and that identities must not be addressed as a unidimensional concept (Collins, 1990; Crenshaw 1989).

As a profession concerned with addressing racism, inequity, disparity and discrimination, social workers can no longer overlook the systemic marginalization of fat bodies in and outside of their practice. Child welfare workers, for one, have become additionally implicated as childhood 'obesity' rates rise alongside debates over 'obesity as neglect' and what the role of social work intervention is in these cases (Friedman, 2015). Examining the impacts of fatphobia in social work practice only further highlighted the disproportionate risk involved for BIPOC who come into contact with child welfare (Friedman, 2015). There is a known overrepresentation of Black and Indigenous children in North American child welfare systems and in the case of fat children, "overwhelming(ly), it is the mother who is blamed, especially if that mother is poor, working class, black, or Hispanic" (Cooper Stoll, 2019, p. 430). As the 'war on obesity' wages, unaddressed fatphobia only serves to perpetuate the continued separation of Black and Indigenous children from their families as a result of child welfare intervention.

Is Fat Acceptance the Alternative?

In order to discuss a future that abolishes binary obesity narratives and embraces the benefits of fat acceptance, I must acknowledge again, as I did at the beginning of this document, that the intention here is not to debate, disprove or engage with the "fat is unhealthy" paradigm. Fat acceptance continues to be misunderstood and mislabeled as "a celebrating obesity" or "glorifying of obesity". And this is simply not the case. Fat acceptance seeks health, equity and acceptance for all bodies. A fellow fat, social justice worker articulated the point best when she stated:

> Promoting obesity is not a real thing and it never has been. There are no multimillion- dollar marketing campaigns telling thin people to get fat quick. Or a 72.7-billion-dollar weight gain industry in the U.S alone. Or government funded initiatives aimed at eliminating the existence of thin people. Or messages to thin people that if they can neverbe fat then their life isn't worth living. But all of those things do live in reverse for fat people. The entire concept of promoting obesity is a myth that's used to silence fat peoplewhen we advocate for the basic human rights, we're so often denied…like equal access… or just basic happiness and freedom from living in shame and abuse. The only things we are promoting are kindness respect and equality. Fat people we have always deserved equal rights and ethical treatment-the only difference is now we're saying that out loud (Fuhlendorf, H., 2020b).

Fat acceptance appears to be a growing, social movement challenging the way many North American's are currently taking up intersectional work and practice. Social spaces have begun to transform and reimagine notions of 'normativity', supplanting diversity and perspectives that negate binary ways of beingand doing. Despite these shifts, much work is still required at all levels of society to create change and acceptance for fat bodies. Fat acceptance does not create change if it remains a social movement.

In August 2020, the summer I was completing the first draft of this thesis, Obesity Canada in partnership with the Canadian Association of Bariatric Physicians and Surgeons released a set of eighty Canadian practice guidelines (CPG). These guidelines were developed for healthcare practitioners and policy makers and are “intended to improve the standard of, and access to care for individuals with obesity in…Canada” (Wharton et al., 2020, p. E876). This will be the first time, on a global level that national clinical guidelines have included weight stigma content, which is in some ways a step forward. Upon asking members of the fat activism community in Victoria, B.C what their feelings were about these guidelines, many of them acknowledged the visible shift but indicated that upon reading the CPG’s, an unsettling feeling remained that could not be easily identified. I proposed then and now that this unsettled feeling can be traced back to the maintained centrality of the ‘obesity’ and ‘obesity as disease’ narratives, both which remain highly visible within this report. The thirteen-page document housing the eighty CPG’s uses the term ‘obesity’ over two hundred times reporting on ‘obesity as a disease’, the continued necessity for the ‘treatment of obesity’, and deficits created by the ‘increased health care costs of obesity’ (Wharton et al., 2020). The report acknowledges that weight centric frameworks are less useful in patient-centered ‘obesity management’ while continuing to propose a framework that is exactly that. The report released with the guidelines recognizes that many of the recommendations remain weight-loss focused but claim this is only due to limits in existing literature such as the majority of studies being concentrated on weight-loss outcomes (Wharton et al., 2020). The release of these guidelines in Canada are similarly timed to other shifts in ‘obesity’ care occurring around the globe like the Better

Health Plan in the UK which suggests fat individuals owe it to National Health Services to 'get healthy' (NHSUK, 2020). In Denmark, the aforementioned weight loss campaign proposed by the health authority intends to impose weight loss programs on individuals seeking social services, forcing those in need to accept generalized, obesity centric diet advice in order to gain supportive resources (Amlund, 2020).

It seems that citizens of the world feel a newfound sense of freedom due to body positivity movements, while 'obesity' paradigms and fatphobic policy and practice persist. Continuing conversations that take up the impacts of fatphobia and the benefits of fat acceptance have become crucial within the fields of health and social work now more than ever (Friedman, 2012). There is an absence of disputation to dominant body narratives, and this is reflected broadly within the fields of social work and medical practice. As a result, frameworks that operationalize fat acceptance have become necessary, like Health at Every Size which takes a weight-neutral approach to policy and decision making and is seen as a promising public health practice (Bacon, 2010). HAES (Bacon, 2010) specifies a need for addressing healthand care differently by rejecting the pathologization of size and building respect for "the inherentdiversity of body shapes and sizes". With a HAES framework, this is done through equalizing access to information and services, attention in practice to the whole person, including socioeconomic status, race, gender, sexual orientation in addition to emotional, mental and physical wellbeing (Bacon, 2010). In clinical settings, Health at Every Size principles have already begun being integrated by social workers therapeutically to increase client awareness, self-acceptance and understanding of impeding structures and systems (Friedman, 2012). HAES and other fat liberation movements offer opportunity for all practitioners to reimagine care practices while developing more wholistic and appropriate means of addressing health and related issues.

Limitations & Areas for Future Research

The significant benefits of fat acceptance on overall mental, emotional and physical wellness have been and should continue to be studied in future research, looking at larger more diverse sample groups. A lack of diversity among participants and a small sample group (4-5 participants) can be considered limiting to next steps and generalizability. Limiting factors also include participant recruitment from fat liberation and acceptance social media groups. In some ways choosing participants pre-exposed to fat studies or fat acceptance could indicate bias and alimitation to this body of work. However, recruitment from fat acceptance groups acted as a wayto offset risks or harms associated with body size, image and internal/external fatphobia.

Individual studies specific to particular fields or populations could prove invaluable. Building on the healthcare context could draw stories and perspective from nursing staff, physicians, dieticians, doctors of natural medicine, chiropractic's and other fields. Brief consideration was given to recruitment of individuals who hold dual roles such as health care workers who are also fat and accessing medical care. With a small-scale research project, it was crucial to hear from and centralize fat voices and patients. Additionally, dual roles may have clouded outcomes and grown the scope of the project beyond what was possible for this thesis work. In future, expanding the *FBS* study to include overlooked participant groups, especially those absent from previous studies, would further thicken the base of literature and importance ofthis topic. Groups could include fat self-identified males, insurance providers, fat foster parents or potential adoptive parents, educators, social workers or policy makers. Studies might address mental health factors, disordered eating, sexual health.

Indigenous communities are expansive, and pan-Indigenizing has had harmful and long-term effects. Examining fatness and fatphobia within Indigenous populations should be community driven, land and nation specific, culturally relevant, and environmentally cognizant. First Peoples across North American fight and continue to fight for land, food and health sovereignty as a result of systemic racism and ongoing marginalization. As a result, Indigenous communities and individuals have unique experiences specific to geographical, historical, cultural and personal location. From the colonial project and its oppressions, 'obesity' has takenon different meanings in Indigenous stories locally and globally necessitating community implemented approaches. Fat acceptance and phobia cannot be discussed without centering the histories, narratives and perspectives of each community and the work already being done to restore health and healing.

Other areas of fat related research must center Black realities and cultural perspectives of size acceptance and fatphobia there within. It is important to note that Western Canada, the site of this project, is home to one of to the largest, growing populations of Black and Indigenous people (Stats Canada, 2016; Stats Canada, 2019). Other notable current studies within Canada appear to focus on growing 'obesity' and 'obesity related disease' rates among Black, Indigenous and other racialized communities (CBC, 2015) without centralizing systemic inequity, systemic racism and the effects. I would suggest that the unique needs of each geographical region and community must be considered in order to address challenges related to health, such as early detection and screening. Current views on health and mortality often fail to cosndier the policies and perspectives perpetuating factors like avoidance and health disparity. As well, generalized solutions to health perpetuate binary lenses such and ablest notions such as improved walking trail access, healthy food information and smoking cessation (CBC, 2015). These solutions ignore current realities of racism, violence and systemic oppression and places the burden of responsibility upon the individual. The intersection of poverty and fatness begs entirely other frameworks of inquiry.

Responsibility is placed on the individual to access care instead of asking practitioners to examine their biases, approaches to practice and to locate better ways to support the healthcare process. Marginalized bodies and bodies of color have suffered at the hands of western medicine for generations and identifying, addressing and offsetting those harms in every waypossible is pertinent to good care and good health.

Space must be made to consider ‘fat’ broadly in order to expand the dominant narrative currently excluding fat bodies from equitable care. Fat individuals are much more than additionalflesh and too many calories. Fatness intersects with every identity, race, class, culture and abilityand no person is safe from the effects of fatphobia within the current context of Canadian or North American healthcare.

Conclusion

Fat acceptance and fat liberation movements have only increased visibility of the work Black and 2SLGBTQIA+ people have done for so long. By acknowledging the socially constructed nature of fatness and the racist history of fatphobia all bodies have an opportunity to avoid being silenced by white, western, patriarchal and misogynist standards infecting North American societies. The decades of underground advocacy and the burgeoning body of research within fat studies provides new understanding of consciousness and fatness. Within health contexts, fat consciousness offers a greater ability to quantify and improve shared human experience without generalizing or conflating intersects of identity.

Earlier in 2020, news broke in British Columbia of emergency room doctors and nurses playingtheir version of the ‘Price is Right’ *on* Indigenous patients (Barrera, 2020). Health care workers were found to be “involved in a “game” of guessing the blood-alcohol level of Indigenous emergency room patients” (Barrera, 2020, para. 1) instead of looking for medical causes for theER visit. Just five years before a local Vancouver Island physician was merely fined and suspended for 6 months after taking and sharing “naked photos of [an] obese patient” (2020).

What would the outcome of this situation have looked like if the patient was of ‘average’ size? Would this have been considered sexual assault?

Disbelief and dismissal are cloaking a system built around white supremacy, racism, patriarchal influence, inequity and discrimination. Through this research, I have cannot deny that lives are being lost either within this system or as a result of it. Many of these factors are involved in the disproportionate care and health outcomes seen in fat communities but the interwoven history and current effects of systemic racism sits at the root (Strings, 2019). Dismantling these oppressive threads is or should be currently at the helmof political priorities. In a 2020 address, NDP Leader Jagmeet Singh recognized that the way through systemic racism in this country isn’t going to be simple or straight forward, but that there are small ways we as a country could begin to change (Singh, 2020). I would suggest that ‘small’ steps toward progress might include societal and medical recognition of fatphobia as an oppressive systemic issue rooted in white supremacy; recognition that obesity narratives only work to servecapitalism and not human bodies; fixed binaries of health and bodies are no longer serving patients and that the ‘war on obesity’ only further perpetuates the war against Black and Indigenous people in North America.

Though the *FBS* study was small and not at the point of generalizability, it had meaningful outcomes. Other researchers have suggested a study intent on bringing understandingto the nature of a phenomenon, in this case fatphobia, may use a relatively small sample size as long as the researcher acknowledges that even when similar themes are discussed by many participants in the study, generalizability cannot be claimed (Thorne, 2008). I believe, when positioned within the rapidly growing body of fat studies work and activisms, generalizabilitydoes not need to be claimed, it becomes evident.

Fatness, fatphobia and its effects demand far more critical research and activism in policy, law and practice to establish recognition and rights for the diversity of fat people. As demonstrated through this work, fat bodies are facing a multi-system struggle with oppression only serving to reinforce discrimination and negative mental, physical and economic outcomes. The prevalence of weight-related discrimination is increasing (Puhl & Heuer, 2009). In the workplace, fat people are less likely to get jobs or promotions despite qualifications and make less money than their thin counterparts for doing same work; gaps in wage and employment werefound to be even wider for fat, racialized individuals and women; fat students were found to be graded more harshly and fat teachers, less likely to receive respect in their roles; Fat health seekers are denied health insurance and medical care, are more frequently accused of medical malpractice and negligence and receive an overall lower quality of care across the board (Fuhlendorf, 2020b; Puhl & Heuer, 2012).

Conflating all fat people into the category of unhealthy or ‘obese’ denies opportunity, limits options and inhibits diagnosis and treatment processes. Current approaches to body size or health maintain a narrow, simplistic view that perpetuates avoidable harms and suffering upon all bodies. This study has shown that fat stigma and phobia are felt across a spectrum of communities, guiding many at an early age to dislike and change who we are. Long existing fatphobia has disallowed most practitioners (and members of society) from seeing fat as separate to health.

The fear of fat pervades our social norms, medical spaces, educational interactions and political realms (Gordon, 2020). Perhaps the challenge then becomes not defining more ways to decrease 'obesity', like potentially hazardous pharmaceuticals and surgeries, but ways to decrease fatphobia and weight bias in healthcare and broader societies. A shift in narrative may allow fora shift in fat consciousness contributing to anti-racist work in healthcare, improved policy change, decision making processes in healthcare and improved health and wellbeing for bodies fat and otherwise.

Labelling every fat body as diseased based on proportionality or added flesh ignores whatshould now be obvious: All bodies are different, and the conflation of size and health has dangerous and devastating consequences. Bodies can no longer be denied constitutional freedoms based on race, presentation, gender or social location. Every person deserves and has a right to access care that is respectful and wholistic, not harmful or humiliating because all bodies, are good bodies.

Bibliography

5 new primary care networks coming to Vancouver Island. (2020, September 16). *CTV News Vancouver Island.* Retrieved from https://vancouverisland.ctvnews.ca/5-new-primary- care-networks-coming-to-vancouver-island-1.5107486

Absolon, K. & Willet, C. (2005). Putting ourselves forward: Location in Aboriginal research. In L. Brown & S. Strega (Eds.), Research as Resistance: Critical, Indigenous and Anti-oppressive Approaches (pp. 97-126). Canadian Scholars' Press.

Afful, A & Ricciardelli, R., (2015). Shaping the online fat acceptance movement: talking aboutbody image and beauty standards. *Journal of Gender Studies, 24*(4), 453-472. doi: 10.1080/09589236.2015.102852

Amlund, D. (2020). Opinion: Fatphobia in the coronavirus crisis. Retrieved fromhttps://cphpost.dk/?p=112963

Anderson, J. & Bresnahan, M. (2012). Communicating stigma about body size. *Health Communication, 28*(6) 1-13. doi:10.1080/10410236.2012.706792

Archibald, J. (2008). *Indigenous Storywork: Educating the heart, mind, body and spirit.* Vancouver, B.C: UBC Press

Association for Size Diversity and Health. (2009). *Health at Every Size Fact Sheet*. Retrieved from https://www.sizediversityandhealth.org/images/uploaded/HAES%20FACT%20SHEET% 20SM%20rev%206%206%2010.pdf?fbclid=IwAR2yUvlh_YPncMp9X- 6zYWWwWBto4TCniDo9DCNHMRXwFFoU9ns5nkeA5N4

Atlantic Council (2020, July 23*)*. #GoodTechChoices: Addressing unjust uses of data against marginalized communities. Retrieved from https://www.atlanticcouncil.org/blogs/geotech-cues/goodtechchoices-address-unjust-uses-of-data/

Bacon, L. (2010). *The HAES Manifesto*. Retrieved from https://lindobacon.com/HAESbook/pdf_files/HAES_Manifesto.pdf?fbclid=IwAR0qKxq0 8H0FmO55MVZV1WVd1UBMqr6C7q2eq8-c0JhS_N6IVzR_H-1F9hM

Barker, A.J. (2009). The contemporary reality of Canadian imperialism: Settler colonialism and the hybrid colonial state. *American Indian Quarterly*, 33(3) 325-352.

Barrera, J. (2020, June 19). B.C. AFN chief wants medical staff involved in 'heinous' hospital 'game' identified. *CBC News*. Retrieved from https://www.cbc.ca/news/indigenous/bc- hospital-guessing-game-reaction-1.5619968

Bentham, J. & Božovič, M. (1995). *The Panopticon Writings*. London: Verso

Borque-Bearksin, L. (2019). *Gifting Indigenous Wellness Knowledge* [PowerPoint Slides].

Blackstock, O. [@DrOniBee]. (2020, August 9). *Hispanic children *8x* as likely as white children to be hospitalized with COVID-19, while Black children were *5x* as likely.*[Tweet]. Twitter. https://twitter.com/DrOniBee/status/1292651598821371904

Broome, D., Nelson, T.A., Roth, J.D. & Silverman, B. (Executive Producers). (2005- 2016). The biggest loser [TV series]. 3Ball Entertainment, Eyeworks, Reveille Productions (2004–12), Shine America (2012–16), Endemol Shine North America(2020–present), Twenty-Five Seven Productions (2004–16).

Buckman, A.R. (1995). The Body as a Site of Colonization: Alice Walker's Possessing the Secret of Joy. *Journal of American Culture*, 18(2), 89-94**.** doi: /10.1111/j.1542- 734X.1995.00089.x

Budgen, J. & Cantiello, J. (2017). Advantaged and disadvantages of the patient-cantered medical home: a critical analysis and lessons learned. *The Health Care Manager*, 26(4),357-363

Burgard, (2009). What is ‘Health at Every Size?”? In E.Rothblum & S. Solovay (Eds.), *The Fat Studies Reader* (pp. 41-53). New York: New York University Press.

Butina, M. (2015). A narrative approach to qualitative inquiry. *Clinical Laboratory Science*, (28)3, 190-196. Retrieved from http://clsjournal.ascls.org/content/ascls/28/3/190.full.pdf

Cameron, L. (2019). The “good fatty” is a dancing fatty: Fat archetypes in reality television. *FatStudies*, (8)3: 259-278. doi: 10.1080/21604851.2019.1549400

Campos, P. (2004). The Obesity Myth: Why America’s obsession with weight is hazardous toyour health. New York, NY: Penguin Groups

Casazza, K., Fontaine, K.R., Astrup, A., Birch, L.L., Brown, A.W., Bohan

Brown, M.M., Durant, N., Dutton, G., Foster, M., Heymsfield, S.B., McIver, K., Mehta, T., Menachemi,N., Newby, P.K., Pate, R., Rolls, B.J., Sen, B., Smith Jr., D.L., Thomas, D.M., Allison, D.B. (2013). Myths, presumptions and facts about obesity. *N. Engl J. Med*, 368(5): 446-454. doi: 10.1056/NEJMsa1208051

CBC (2015). Rising Obesity Rates. Retrieved from https://www.cbc.ca/news/health/rising-diabetes-obesity-rates-may-put-ethnic-groups-heart-health-at-risk-1.3185285

Chan, A. (2019, December 11). Vancouver Island home to 4 of 10 longest clinic wait times in Canada. *Vancouver Island News*. Retrieved from https://vancocauverisland.ctvnews.ca/vancouver-island-home-to-4-of-10-longest-clinic- wait-times-in-canada-1.4725809

CNN (1998, June 17). Who's fat? New definition adopted. *CNN Interactive*. Retrieved from http://www.cnn.com/HEALTH/9806/17/weight.guidelines/

Cooper, C. (2007). Headless fatties [Online]. London Retrieved from http://charlottecooper.net/fat/fat-writing/headless-fatties-01-07/

Cooper, C. (2016). Fat activism: A radical social movement. HammerON Press, Bristol, England

Cooper Stoll, L. (2019). Fat is a social justice issue, too. *Humanity and Society*, (43)4: 421-441. Retrieved from https://journals.sagepub.com/doi/10.1177/0160597619832051

Eknoyan, G. (YEAR). A history of obesity, or how what was good became ugly and Then Bad. *Advances in Chronic Kidney Disease, 13*(4): 421-427 doi: 10.1053/j.ackd.2006.07.002

Daiute, C. 2014 The Appeal of Narrative in Research. In (Eds.), *Narrative Inquiry: A Dynamic Approach* (1st Cdn. ed). (pp. 1-30). Retrieved from https://www.researchgate.net/publication/270050408_Narrative_Inquiry_A_Dynamic_A pproach_Chapter_One

Dean, M. (1999). Governmentality: Power and Rule in Modern Society. Sage: Thousand Oaks, CA

De Leeuw, S., Greenwood, M. & Cameron, E. (2010). Deviant constructions: How governmentspreserve colonial narratives of addictions and poor mental health to intervene into the lives of Indigenous children and families in Canada. International Journal of Mental Health Addiction, 8, 282-295. doi: 10.1007/s11469-009-9225-1

Denhart, A. (2020, January 28). Forget the pounds. 'The Biggest Loser' tries to shed critics of its weight-loss plan. Los Angeles Times. Retrieved from https://www.latimes.com/entertainment-arts/tv/story/2020-01-28/the-biggest-loser-weight-loss-nbc-universal-usa-network

Depalma, R. (2010). Socially just research for social justice: Negotiating consent and safety in aparticipatory action research project. *International Journal of Research & Method in Education, 33(*3): 215-227.

Dobson, R. (2003). Blood pressure readings may be wrong for overweight patients. *BMJ: BritishMedical Journal*, 327(7413), 468. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1142484/

Doctors pay model needs to change to end 'one issue per visit policy: advocacy group. (2015, 22September). Retrieved from https://globalnews.ca/news/2232914/doctors-pay-model- needs-to-change-to-end-one-issue-per-visit-policy-advocacy-group/

Driskill, Q-L., Finley, C., Gilley, J. & Morgenson, S. (2011). Queer Indigenous Studies

Dury, C. & Louis, M. (2004). Exploring the association between body weight, stigma of obesity, and health care avoidance. *Journal of the American Academy of Nurse Practitioners* 14(12):554-60.

Ernsberger, P. (2009). Does social class explain the connection between weight and health? In E.Rothblum & S. Solovay (Eds.), *The Fat Studies Reader* (pp. 25-36). New York: New York University Press.

Fikkan, J.L. & Rothblum, E. D. (2012). Is fat a feminist issue? Exploring the gendered nature ofweight bias. Feminist Forum, 66: 575-592. doi: 10.1007/s11199-011-0022-5

Foucault, M. (1978). The History of Sexuality: An Introduction, vol 1 [1976]. Trans. R. Hurley.

Foucault, M. (1975). Discipline and Punish: The Birth of the Prison. New York: Vintage

Freespirit, J. (1973). Fat liberation manifesto. Retrieved from https://laurietobyedison.com/body-impolitic-blog/tag/fat-liberationmanifesto/?fbclid=IwAR0ojZSXlZuWkuqxvZzYuPMaL mTR9qCkjhvzTdHLGNSfbdWKvtC7be7GnCA

Friedman, M. (2012). Fat is a social work issue: Fat bodies, moral regulation and the history ofsocial work. *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity and Practice* 1: 53-69

Friedman, M. (2015). Mother blame, fat shame, and moral panic: “Obesity” and child welfare. *Fat Studies, 4*(1): 14-27, doi: 10.1080/21604851.2014.927209

Frohard-Dourlent, H., Strayed, N. & Saewyc, E. (2017). *“The agency to choose what’s right for their body”: Experiences with gender-affirming surgery in British Columbia.* Vancouver,BC: Stigma and Resilience Among Vulnerable Youth Centre, School of Nursing, University of British Columbia.

Fuhlendorf(a), H. [@hannah_talks_bodies]. (2020, August 3). *The weird and racist history of the BMI.* #bodymassindex #health #fat #fatacceptance #fatliberation #fatphobia #medicalbias [video]. TikTok. https://vm.tiktok.com/J67pPUu/

Fuhlendorf(b), H. [@hannah_talks_bodies]. (2020, September 22). Stop promoting obesity.[video]. Instagram. https://www.instagram.com/hannah_talks_bodies/

Gamez, D. (2014). The measurement of consciousness: A framework for the scientific study of consciousness. *Frontiers in Psychology,* 5(714), 1-14. doi: 10.3389/fpsyg.2014.00714

Gordon, A. (2020). Introduction. In *What we don’t talk about when we talk about fat* (pp. 1-12). Boston, Massachusetts: Beacon Press

Griffin, R.M. (n.d.). Obesity epidemic “astronomical”. Retrieved from https://www.webmd.com/diet/obesity/features/obesity-epidemic-astronomical#1

Guba, E.G., & Lincoln, Y.S. (1989). *Fourth generation evaluation*. Newbury Park. CA: Sage.

Guthman, J. (2009). Teaching the politics of obesity: insights into neoliberal embodiment &contemporary biopolitics. *Antipode,* 41(5): 1110-1133, doi: 10.1111/j.1467- 8330.2009.00707.x

Guthman, J. & DePuis, M. (2006). Embodying neoliberalism: economy, culture, and the politicsof fat. *Environment & Planning D: Society & Space.* 24(3): 427-448

Gutting, G. (2005). Foucault: A very short introduction. Oxford University Press: New York

Hagen, S. (2019, October 20). I am not a body positivity activist campaigner; I am a fat liberationist. I do not care if you love your body or not, I care about abolishing the systemic discrimination and abuse that fat people endure on a daily basis. Body positivityis fine, but it doesn't at all fix the problem. [Tweet]. Retrieved from https://twitter.com/SofieHagen/status/1185994062261870592

Haley [@the_queer_counselor]. (n.d.). Posts [Instagram profile]. Instagram. Retrieved May 19,2020, from https://www.instagram.com/the_queer_counselor/

Halperin, D. (1995). Saint Foucault: Towards a Gay Hagiography. Oxford University Press,Oxford.

Halse, C. (2009). Bio-citizenship: Virtue discourses and the birth of the bio-citizen. In Jan Wright & Valerie Harwood (Eds.), Biopolitics and the obesity epidemic (pp. 45–59).New York, NY: Routledge.

Hart, E. [@ihartericka]. (2020). Black people are not healthy due to diets this statement is false. Instagram. https://www.instagram.com/p/CEC741Wgq_u/

Hayden, F. (2015). Finally, a study that confirms what I knew all along: fat acceptance is goodfor our health. Independent. Retrieved from https://www.independent.co.uk/voices/finally-a-study-that-confirms-what-i-knew-all- along-fat-acceptance-is-good-for-our-health-10440615.html

Health Canada. (2019). Chronic pain in Canada: laying a foundation for action. Retrieved fromhttps://www.canada.ca/content/dam/hc-sc/documents/corporate/about-health- canada/public-engagement/external-advisory-bodies/canadian-pain-task-force/report- 2019/canadian-pain-task-force-June-2019-report-en.pdf

Hewings-Martin, Y. Increasing diversity in clinical trials: what can doctors, regulators, and patients do? Medical News Today. Retrieved from https://www.medicalnewstoday.com/articles/increasing-diversity-in-clinical-trials-what-can-doctors-regulators-and-patients-do

Honeycutt, K.S. (1999). Body imperfect: The social construction of fatness. Retrieved from https://deepblue.lib.umich.edu/handle/2027.42/131671

hooks, b. (1992). *Black Looks: Race and Representation*. Boston, MA: South End

How disparities in health care hurt Black and Indigenous people. (2020, September 7). Retrieved from https://the-peak.ca/2020/09/how-disparities-in-health-care-hurt-black-and- indigenous-peoples/

Indian Act. (RSC 1985, c 1-5). Retrieved from https://laws lois.justice.gc.ca/eng/acts/i-5/ Jackson, G. (2019, September 1).

Why don’t doctors trust women? Because they don’t know much about us. *The Guardian*. Retrieved from https://www.theguardian.com/books/2019/sep/02/why-dont-doctors-trust-women- because-they-dont-know-much-about-us

Kafer, A. (2013). Feminist, Queer, Crip. Critical Encounters. Indiana: Indiana University Press

Kaomea, J. (2015). Qualitative Analysis as Hoʻokuʻikuʻi or Bricolage: Teaching EmancipatoryIndigenous Research in Postcolonial Hawaiʻi.

Kersh, R. & Morone, J. (2002). The politics of obesity: Seven steps to government action. *Politics and Public Health*, 21(6): 142-153.

Kirby, M. (2012, July 18). Investors in obesity industry are sure to make a big fat profit. *The Guardian*. Retrieved from https://www.theguardian.com/commentisfree/2012/jul/18/business-obesity-big-fat-profit

Kovach, M. (2009). *Indigenous Research Methodologies: Characteristics, conversations andcontexts*. University of Toronto Press: Toronto

Lebow. V. (1955). Price competition in 1955. *Journal of Retailing*. Retrieved from https://hundredgoals.files.wordpress.com/2009/05/journal-of-retailing.pdf

Lee, J.A. & Pausé, K. (2016). Stigma in practice: Barriers to health for fat women. Frontiers inPsychology, 7(2063): 1-15

Lilley, B. (28 May, 2019). Trudeau looks for more ways to pick your pocket. *The Toronto Sun*. Retrieved from https://torontosun.com/opinion/columnists/lilley-trudeau-looks-for-more-ways-to-pick-your-pocket

Liu, K.A. & Dipietro Mager, N.A. (2016). Women’s involvement in clinical trials: historical perspectives and future implications. *Pharmacy Practice*, 14(1): 708-723. doi: 10.18549/PharmPract.2016.01.708

Lloyd, D. & Wolfe, P. (2016). Settler colonial logics and the neoliberal regime. *Settler Colonial Studies*, *6*(2), 109-118. doi: 10.1080/2201473X.2015.1035361

Lorde, A. (1984). *Sister outsider: Essays and speeches.* New York, N.Y: Ten Speed Press

Lown, B. (2007). The commodification of health care. PNHP Newsletter. Retrieved from http://www.pnhp.org/publications/the_commodification_of_health_ care.php?page=all

Lysaght, M. (2009). 'Your wealth is your health': A study of the commodification of healthservices in Ireland. Critical Social Thinking: Policy and Practice, 1(1): 297-314

Mays, J.C. & Newman, A. (June 26, 2020). Virus is twice as deadly for Black and Latino peoplethan whites in NYC. The New York Times, Retrieved from https://www.nytimes.com/2020/04/08/nyregion/coronavirus-race-deaths.html

McAllum, K., Fox, S., Simpson, M. & Unson, C. (2019). A comparative tale of two methods:how thematic and narrative analyses author the data story differently. CommunicationResearch and Practice, 5(4), 385-375 doi: 10.1080/22041451.2019.1677068

Merrian-Webster Dictionary. (n.d.). In Merriam-Webster.com dictionary. Retrieved August 19,2020 from https://www.merriam-webster.com/dictionary/care

Miller, J-A. & Miller, R. (1987). Jeremy Bentham's Panoptic Device. The MIT Press. 1(3-29). Retrieved from https://www-jstor-org.ezproxy.library.uvic.ca/stable/pdf/778327.pdf?refreqid=excelsior%3Abe00fe35fb6665d5f54c0c05a7ce370e

Million, D. (2013). *Therapeutic Nations Healing in an Age of Indigenous Human Rights*. Tucson: The University of Arizona Press.

Million, D. [Issi]. (2015, January 5*). Indigenous feminisms' affective response to state violence* [video]. YouTube. https://www.youtube.com/watch?v=orUbZ59MRnI&t=1444s

Naderifar, C., Goli E, & Ghaljaie, F. (2016). Snowball Sampling: A purposeful method ofsampling in qualitative research. Developing Medical Education, (14) 3: 533-554

NAAFA Official. (2011, March 21). *Was it ever okay to be fat? With Dina Amlund* [Video file]. Retrieved from https://www.youtube.com/watch?v=bhR1e59voAI

"Naked Photos of Obese Patient". (July 15, 2015). Retrieved from https://vancouverisland.ctvnews.ca/doctor-who-emailed-naked-photos-of-obese-patient- suspended-fined-1.2482046

National Initiative for Eating Disorders, (2016). *Eating Disorders in Canada*. Retrieved fromhttps://nied.ca/about-eating-disorders-in-canada/

NEJM Catalyst (2017). *Patient-Centered Care? Explore the definition, benefits, and examples ofpatient-centred care.* Retrieved from https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0559

National Health Services UK. (2020). *Live Well*. Retrieved from https://www.nhs.uk/live-well/

(Neustaeter, B. (2020, June 3). No difference between racism in Canada and the U.S., activists say. Retrieved from https://www.ctvnews.ca/canada/no-difference between-racism-in-canada-and-the-u-s-activists-say1.4967681?cache=zviomxnayn%3FclipId%3D89926%3Fot%3DAjaxLayout

Newton, I. (1675). "On the shoulders of giants. Retrieved from https://link.springer.com/chapter/10.1007/978-1-4471-0051-5_5 Obesity Canada (2020). *Weight Bias*. Retrieved from https://obesitycanada.ca/weight-bias/ Ogilvie, K. & Eggleton, A. (2016). Obesity in Canada: a whole-of-society approach for healthier Canada. Report of the Standing Senate Committee on Social Affairs, Science andTechnology.

Oliver, J.E. (2006). Fat politics. *The real story behind America's obesity epidemic*. Oxford: Oxford University Press

Owen, W. F. (1984). Interpretive themes in relational communication. *Quarterly Journal ofSpeech*, 70(3), 274–287. doi: 10.1080/00335638409383697

Pausé, K. (2018). The HAES files: Why I don't care about health. International Society of Critical Health Psychology. Retrieved from https://ischp.info/2018/04/03/the-haes-files-why-i-dont-care-about-health/

Pendleton, M. (2020). How racism is leading to disproportionate harm during the COVID-19pandemic. *Centre for the Study of Social Policy.* Retrieved from https://cssp.org/2020/07/how-racism-is-leading-to-disproportionate-harm-during-the-covid-19-pandemic/

Phelan, S.M., Burgess, D.J., Yeazel W.L., Hellerstedt J.M. & van Ryn, M. (2015). Impact of weight bias and stigma on quality-of-care outcomes for patients with obesity. *ObesityReviews*, 16: 319-326

Pieterman, R. (2007). The Social Construction of Fat: Care and Control in the Public Concern forHealthy Behaviour. Sociology Compass [Online], 1(1)

Puhl, R.M. & Heuer, C.A. (2012). The stigma of obesity: A review and update. Obesity Journal,17(5), 941-964. Retrieved from http://www.uconnruddcenter.org/resources/upload/docs/what/bias/WeightBiasStudy.pdf

National Inquiry into Missing and Murdered Indigenous Women and Girls. (2019). *Reclaimingpower and place. The final report of the national inquiry into missing and murdered indigenous women and girls.* The National Inquiry. https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Final_Report_Vol_1a-1.pdf

Rossiter, A.B. (1996). A perspective on critical social work. *Journal of Progressive HumanServices*, 7(2): 23-41

Rothblum, E. & Soloway, S. (Eds.). (2009). *The fat studies reader*. New York, NY, US: NewYork University Press.

Russel, C., Cameron, E., Socha, T. & McNinch, H. (2013). Fatties cause global warming: Fat pedagogy and environmental education. Canadian Journal of Environmental Education,18: 27-45

Said, E.W. (1978). *Orientalism*. London: Routledge & Kegan Paul

Severson, A. (2019, June 6). Why I'm trading body positivity for fat acceptance. Healthline. Retrieved from https://www.healthline.com/health/fat-acceptance-vs-body-positivity?fbclid=IwAR39kgfDz2gj-SYrnSQVHKqe1YWxMqfphXBxQ6wpEGMsxWddSzU7TUflhHg

Shrader, A. (2019). Consumer capitalism: definition, examples and effects. Bizfluent. Retrieved from https://bizfluent.com/info-8164327-pros-cons-economic-system.html

Smith, L.T. (2012). Decolonizing methodologies: Research and Indigenous peoples (2nd ed.). London, UK: Zed Books

Smith, A. (2011). In Driskill et al., (Ed.), *Queer Indigenous Studies* (pp. 43-65). Tucson: University of Arizona Press:

Snyder, H. (2019). Literature review as a research methodology: An overview and guidelines. *Journal of Business Research*, 104(2019): 333-339

Statistics Canada. (2016). Obesity in Canada: Prevalence among Aboriginal populations. Retrieved from https://www.canada.ca/en/public-health/services/health- promotion/healthy-living/obesity-canada/prevalence-among-aboriginal-populations.html

Strings, S. (2019). *Fearing the black body: Racial origins of fat phobia.* New York, NY: New York University Press

Suffering from high BP? Not really, your doctors' manual devices may be at fault. (2017, March 21). *Hindustan Times*. Retrieved from https://www.hindustantimes.com/health-and-fitness/suffering-from-high-bp-not-really- your-doctor-s-manual-devices-may-be-at-fault/story-c6GCYtHHJ2ydQTn4Y07J3J.html

Tarantino, J., Wallace, C., Bowman, R., Keels, J., Davidson, G., Mireles, T. & Nowzaradan, J.(Executive Producers). My 600-LB Life. (2012-Present). Megalomedia.

The Canadian Medical Protective Association. (2007). *Collaborative care: A medical liability perspective*. Retrieved from https://www.cmpa-acpm.ca/en/advice publications/handbooks/collaborative-care-summary

The Takeaway (2017). The other f word: The politics of being fat. Retrieved from https://www.wnyc.org/story/other-f-word-politics-being-fatt/

Thorne, S. (2008). Scaffolding a study in interpretive description in Beck CT, (Ed.), InterpretiveDescription: Qualitative Research for Applied Practice, (2nd ed.) (pp. 60-79) New York:Routledge

Trainer, S., Wutich, A. & Brewis, A. (2017) Eating in the Panopticon: Surveillance of food and weight before and after bariatric surgery. Medical Anthropology: Cross Cultural Studiesin Health and Illness, 36(5), 500-514, doi: 10.1080/01459740.2017.1298595

Turpel-Lafond, M.E. (2021). In plain sight: Addressing Indigenous-specific racism and discrimination in B.C. health care.

Türken, Nafstad, Blakar & Roen (2016). Making sense of neoliberal subjectivity: A discourseanalysis of media language on self-development. *Globalizations,* 13(1): 32-46, doi: 10.1080/14747731.2015.1033247

TV Guide (2002). My 600-lb life season 9 episodes. Retrieved from https://www.tvguide.com/tvshows/my-600-lb-life/episodes-season-9/1030102704/

Webster, J. & Watson, R.T. (2002). Analyzing the past to prepare for the future: Writing a literature review. *Management Information Systems Quarterly*, 26(2), xiii-xxiii

Werner, A. & Malterud, K. (2003). It's hard work behaving as a credible patient: encounters between women with chronic pain and their doctors. Social Science & Medicine, 57(8):1409-1419, doi: 10.1016/S0277-9536(02)00520-8

Western States Center (2020). A history, the construction of race and racism. In *Dismantling Racism Project: A Resources Book for Social Change Groups*. Retrieved from https://www.racialequitytools.org/resourcefiles/Western%20States%20%20Construction%20of%20Race.pdf

Wharton, S., Lau, D., Vallis, M., Sharma, A., Biertho, L., Campbell-Scherer, D., Adamo, K., Alberga, A., Bell, R., Boulé, N., Boyling, E., Brown, J., Calam, B., Clarke, C., Crowshoe, L., Divalentino, D., Forhan, M., Freedhoff, Y., Gagner, M., Glazer, S., Grand, C., Green, M., Hahn, M., Hawa, R., Henderson, R., Hong, D., Hung, P., Janssen, I., Jacklin, K., Johnson-Stoklossa, C., Kemp, A., Kirk, S., Kuk, J., Langlois, M-F., Lear, S., McInnes, A., Macklin, D., Naji, L., Manjoo, P., Morin, M-P., Nerenberg, K., Patton, I., Pedersen, S., Pereira, L., Piccinini-Vallis, H., Poddar, M., Poirier, P., Prud'homme, D., Ramos Salas, X., Rueda-Clausen, C., Russell-Mayhew, S., Shiau, J., Sherifali, D., Sievenpiper, J., Sockalingam, S., Taylor, V., Toth, E., Twells, L., Tytus, R., Walji, S., Walker, L. & Wicklum, S. (2020). Obesity in adults: A clinical practice guideline. *Canadian Medical Association Journal*, 192(31): E875-E891. Retrieved from https://www.cmaj.ca/content/cmaj/192/31/E875.full.pdf

White, (n.d.). The Master's Tools: The Wisdom of Audré. Retrieved from https://www.activistgraduateschool.org/on-the-masters-tools

Whitinui, P. (2013). Indigenous autoethnography: exploring, engaging, and experiencing "self" as a native method of inquiry. *Journal of Contemporary Ethnography*, 43(4): 456-487. doi: 10.1177/0891241613508148

Williams, D.R. & Mohammed, S.A. (2009). Discrimination and racial disparities in health: Evidence and needed research. *J Behav Med*, 32(1): 1-38. doi:10.1007/s10865-008-9185-0. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2821669/

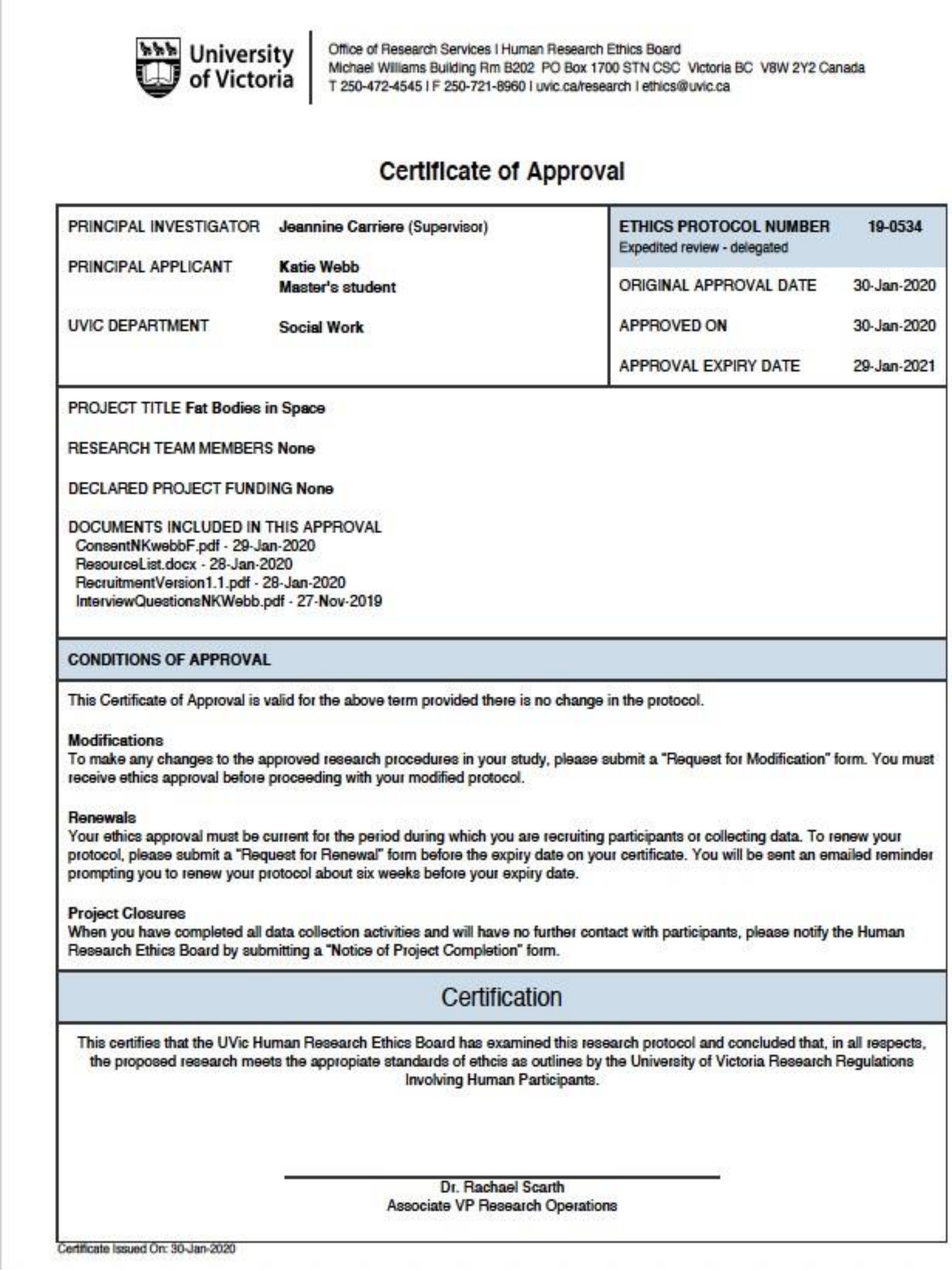
Woman uses obituary to advocate against fat shaming in the medical profession. (2018, July 30). *The Star*. Retrieved from https://www.cbc.ca/news/canada/newfoundland-labrador/fat-shaming-medical-1.4766676.

Yingling, T. (2016). Fat futurity. Feral Feminisms Untimely Bodies: Futurity, Resistance, and Non-Normative Embodiment, 5: 28-43

Your Fat Friend [@yrfatfriend]. (n.d.). Posts [Instagram profiles]. Instagram. Retrieved June 9,2020, from https://www.instagram.com/yrfatfriend/

Zapata, M. (2016, October 26). The horrifying legacy of the Victoria tapeworm diet: a beauty fatthat continues to haunt us. *Atlas Obscura*. Retrieved from https://www.atlasobscura.com/articles/the-horrifying-legacy-of-the-victorian-tapeworm- diet

Appendix A-Ethics Certificate of Approval



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Certificate of Approval

PRINCIPAL INVESTIGATOR	**Jeannine Carriere** (Supervisor)	**ETHICS PROTOCOL NUMBER** Expedited review - delegated	**19-0534**
PRINCIPAL APPLICANT	**Katie Webb** **Master's student**	ORIGINAL APPROVAL DATE	30-Jan-2020
UVIC DEPARTMENT	**Social Work**	APPROVED ON	30-Jan-2020
		APPROVAL EXPIRY DATE	29-Jan-2021

PROJECT TITLE **Fat Bodies in Space**

RESEARCH TEAM MEMBERS **None**

DECLARED PROJECT FUNDING **None**

DOCUMENTS INCLUDED IN THIS APPROVAL
ConsentNKwebbF.pdf - 29-Jan-2020
ResourceList.docx - 28-Jan-2020
RecruitmentVersion1.1.pdf - 28-Jan-2020
InterviewQuestionsNKWebb.pdf - 27-Nov-2019

CONDITIONS OF APPROVAL

This Certificate of Approval is valid for the above term provided there is no change in the protocol.

Modifications
To make any changes to the approved research procedures in your study, please submit a "Request for Modification" form. You must receive ethics approval before proceeding with your modified protocol.

Renewals
Your ethics approval must be current for the period during which you are recruiting participants or collecting data. To renew your protocol, please submit a "Request for Renewal" form before the expiry date on your certificate. You will be sent an emailed reminder prompting you to renew your protocol about six weeks before your expiry date.

Project Closures
When you have completed all data collection activities and will have no further contact with participants, please notify the Human Research Ethics Board by submitting a "Notice of Project Completion" form.

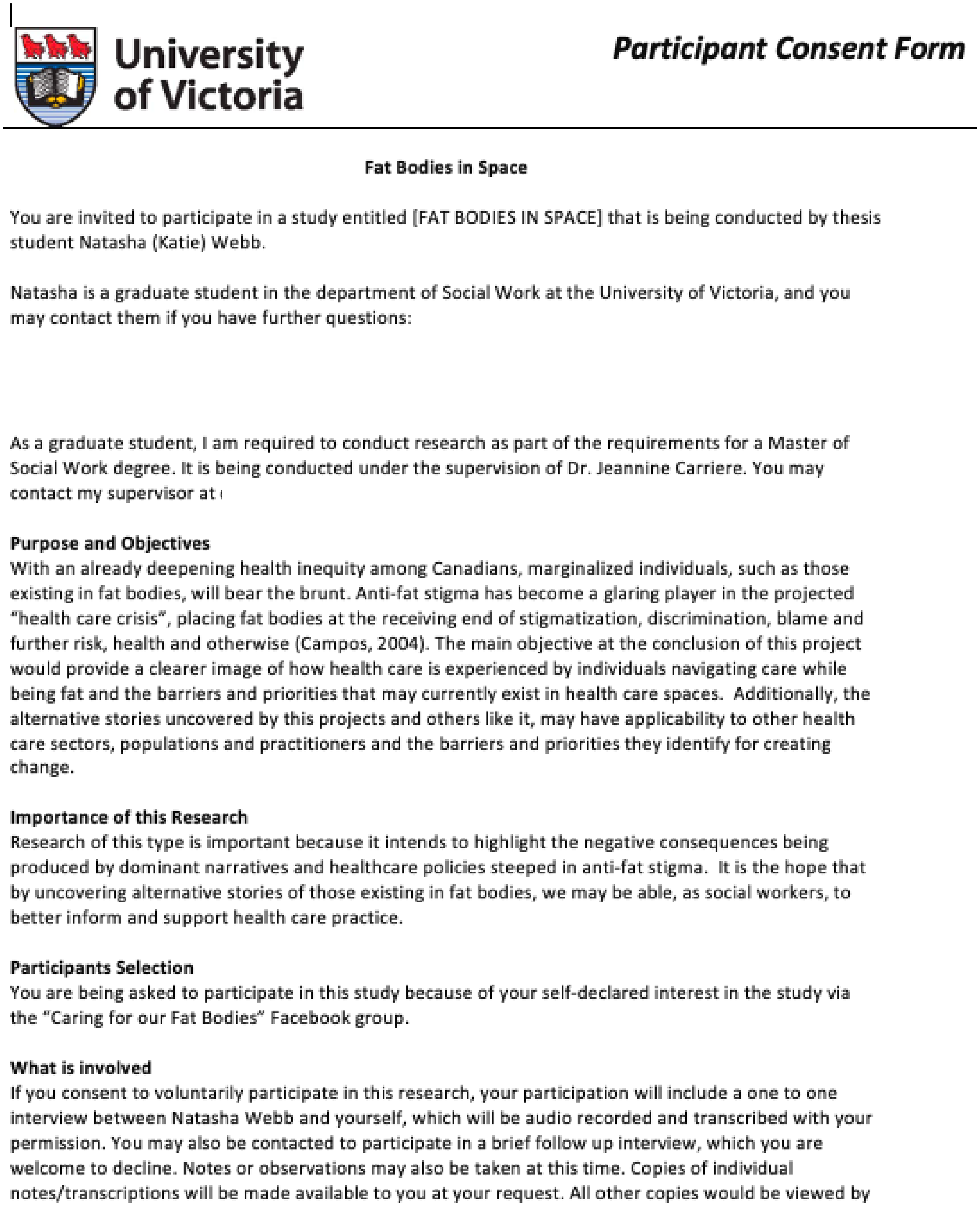
Certification

This certifies that the UVic Human Research Ethics Board has examined this research protocol and concluded that, in all respects, the proposed research meets the appropiate standards of ethcis as outlines by the University of Victoria Research Regulations Involving Human Participants.

Dr. Rachael Scarth
Associate VP Research Operations

Certificate Issued On: 30-Jan-2020

Appendix B-Participant Consent Form



University of Victoria

Participant Consent Form

Fat Bodies in Space

You are invited to participate in a study entitled [FAT BODIES IN SPACE] that is being conducted by thesis student Natasha (Katie) Webb.

Natasha is a graduate student in the department of Social Work at the University of Victoria, and you may contact them if you have further questions:

As a graduate student, I am required to conduct research as part of the requirements for a Master of Social Work degree. It is being conducted under the supervision of Dr. Jeannine Carriere. You may contact my supervisor at

Purpose and Objectives

With an already deepening health inequity among Canadians, marginalized individuals, such as those existing in fat bodies, will bear the brunt. Anti-fat stigma has become a glaring player in the projected "health care crisis", placing fat bodies at the receiving end of stigmatization, discrimination, blame and further risk, health and otherwise (Campos, 2004). The main objective at the conclusion of this project would provide a clearer image of how health care is experienced by individuals navigating care while being fat and the barriers and priorities that may currently exist in health care spaces. Additionally, the alternative stories uncovered by this projects and others like it, may have applicability to other health care sectors, populations and practitioners and the barriers and priorities they identify for creating change.

Importance of this Research

Research of this type is important because it intends to highlight the negative consequences being produced by dominant narratives and healthcare policies steeped in anti-fat stigma. It is the hope that by uncovering alternative stories of those existing in fat bodies, we may be able, as social workers, to better inform and support health care practice.

Participants Selection

You are being asked to participate in this study because of your self-declared interest in the study via the "Caring for our Fat Bodies" Facebook group.

What is involved

If you consent to voluntarily participate in this research, your participation will include a one to one interview between Natasha Webb and yourself, which will be audio recorded and transcribed with your permission. You may also be contacted to participate in a brief follow up interview, which you are welcome to decline. Notes or observations may also be taken at this time. Copies of individual notes/transcriptions will be made available to you at your request. All other copies would be viewed by only the researcher/supervisor and destroyed at the completion of project. A follow-up interview may be requested by researcher or participant to ensure transcription and analysis are completed to the participants satisfaction.

Inconvenience

Participation in this study may cause some inconvenience to you, including the giving of an hour or two of your own time. The researcher will make best attempts to work within your schedule and suitability.

Risks

There are some potential risks to you by participating in this research and they include possible emotional discomfort when recalling personal experiences. These risks will be mitigated through informed consent and engaging in the interview process with the participants comfort in mind (i.e. in a space participant feel most comfortable-in person, online, while engaging in an activity). Additionally, participants can withdraw their participation at any time.

Benefits

The potential benefits of your participation in this research may include shared learning, space to be heard and visible while navigating health care and systemic challenges and being a part of something the Fat Community has deemed meaningful and valuable.

Voluntary Participation

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study any information collected from you will be destroyed and not used at your request.

On-going Consent

To make sure that you continue to consent to participate in this research, I will engage in conversations about consent and your approval through the process of this project and at each stage (i.e. initial interview, member-checking, analysis, final thesis project).

Anonymity

In terms of protecting your anonymity, no names or locations will be provided in the final thesis document unless specifically requested. All notes will be reviewed by the researcher and any content likely to identify you will be deleted or otherwise anonymized.

Confidentiality

Your confidentiality and the confidentiality of the data will be contained in password protected word documents and only shared with supervisor Dr. Jeannine Carriere. Participants will be issued a name or number (i.e. Participant #1) and no names will be used in final or public documents or shared with other participants. The interviews will operate with the expectation that what is said during the interviews is kept private and confidential by the researcher and participants. However, what participants decide to share outside of the interview space cannot be controlled by the researcher.

Dissemination of Results

It is anticipated that the results of this study will be shared with others as a final thesis project for the completion of a Master of Social Work degree at the University of Victoria. Additionally, UVIC Theses are made public on the UVIC website at https://www.uvic.ca/library/use/info/grads/thesis/finduvic.php.

Disposal of Data
Data from this study will be disposed of following the successful completion of this thesis project and defense. Electronic data will be erased; paper copies will be shredded or returned to you at your request.

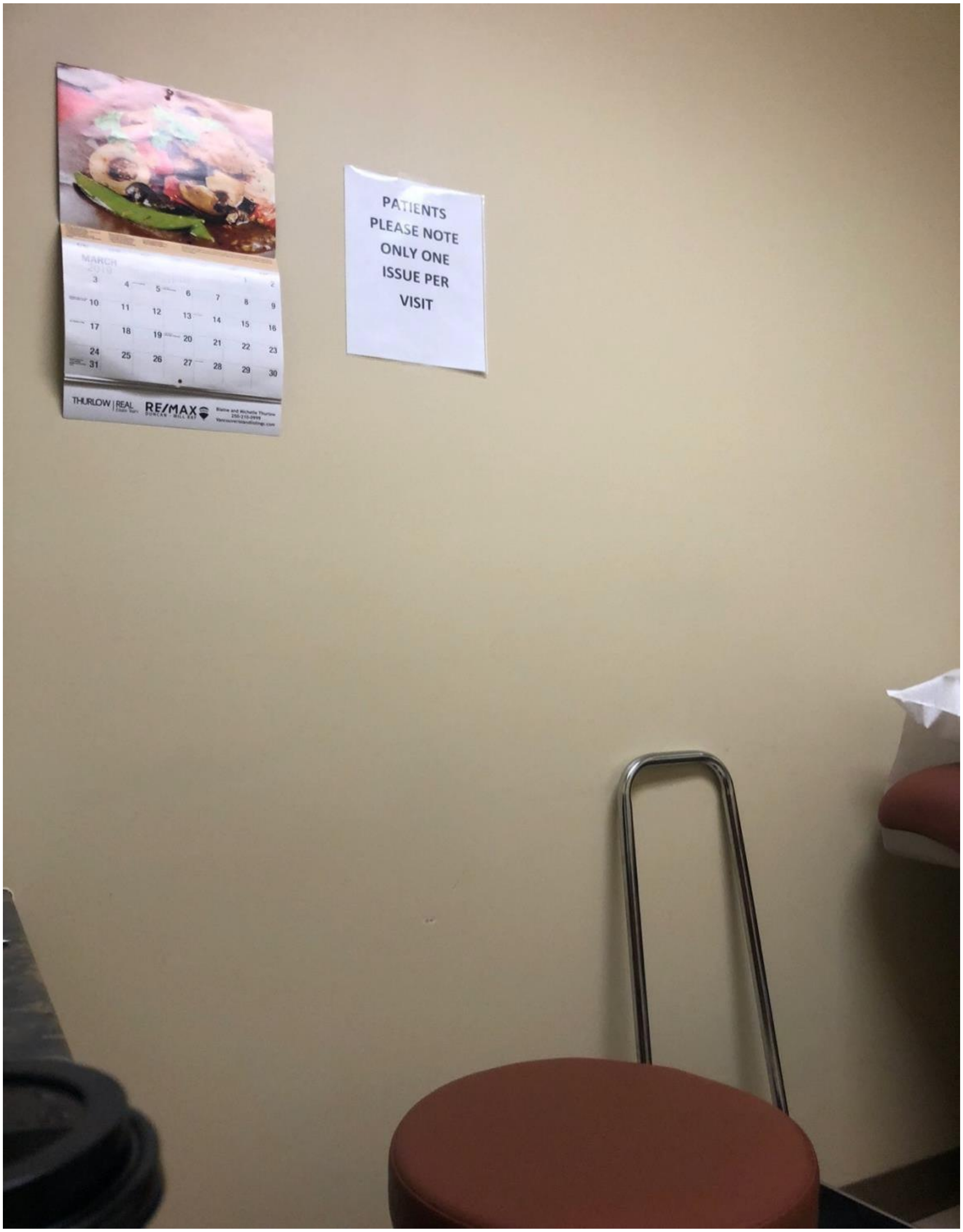
Contacts
Individuals that may be contacted regarding this study include

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you consent to participate in this research project.

Name of Participant	*Signature*	*Date*

Appendix C- “One Issue Per Visit”



Appendix D- Participant Call Out

Upcoming Fat Bodies Research Project!

Working towards the completion of my social work thesis, I have decided to focus my research on Fat Activism and Fat Futures in health. I have heard many stories of the health care experiences of our community and hope to design this study around those stories by interviewing a few participants. The aim is to ask a few open-ended questions centering your health care experiences. You will not be asked to share anything you aren't comfortable with.

Please feel free to contact me if you or anyone you know would be interested in participating and:
-Identify as part of the fat community
-Are living on Vancouver Island
-Recently or currently engaged in health care services
-An interest in sharing your health care stories!

Your identity, personal information and stories will all be kept confidential. Contact me for more details.

Natasha Katie Webb

Appendix E- Interview Questions

Interview questions are indicated with a Q and numeric sequence while prompts were markedwith a P and numeric sequence.

Q1: How did you get involved in the online Facebook group, Caring for our Fat Bodies?

Q2: (Is that part of what drew you to this project?) Tell me about what drew your interest to thisproject?

Q3: In what ways have online spaces such as the group "Caring for our Fat Bodies" made adifference for you?

Q4: The initial call out for this project talked about the stories we shoulder regarding our experiences in healthcare. Do you have a story or stories that came to mind when you think aboutyour own experiences in healthcare?

Q5: What, if anything, has worked well during your journey in healthcare?

Q5.1: What would the ideal healthcare experience look like to you? What can we do inthe future?

Q6: Is there anything more you would like to share or think I should know? P1: Can you describe feelings, opinions, more detailed descriptions P2: "What was that like?"

P3: "What did you think about that?"

P4: "Could you tell me more about how [that] made you feel?

P5: "Could you describe that [conversation] in more detail?" "does anything else come tomind?"