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FAT AND QUEER: A QUALITATIVE EXPLORATION OF WOMENS' EXPERIENCES OF FATPHOBIA

by

Jaidelynn K. Rogers

M.A., Southern Illinois University Carbondale, 2020

A Dissertation
Submitted in Partial Fulfillment of the Requirements for the
Doctor of Philosophy Degree

School of Psychological and Behavioral Sciences
in the Graduate School
Southern Illinois University Carbondale
August 2023

DISSERTATION APPROVAL

FAT AND QUEER: A QUALITATIVE EXPLORATION OF WOMENS' EXPERIENCES OF FATPHOBIA

by

Jaidelynn K. Rogers

A Dissertation Submitted in Partial

Fulfillment of the Requirements

for the Degree of

Doctor of Philosophy

in the field of Psychology

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AN ABSTRACT OF THE DISSERTATION OF

Jaidelynn Rogers, for the Doctor of Philosophy degree in Psychology, presented on June 27, 2022, at Southern Illinois University Carbondale.

TITLE: FAT AND QUEER: A QUALITATIVE EXPLORATION OF WOMENS' EXPERIENCES OF FATPHOBIA

MAJOR PROFESSOR: Kathleen Chwalisz, Ph.D.

A paucity of psychological research exists on the topic of fatphobia, a type of pervasive oppression that occurs for people with plus-size, large, and/or fat bodies. Much of the research that exists about fatphobia focuses on medical ideals, the associated weight stigma, and how these are related to fat people's physical health. Medical researchers have determined that weight stigma is actually more harmful to fat people's health than being fat. Fatphobia impacts women at disproportionate rates. Plus-sized, queer, lesbian, bisexual, and pansexual (LGBTQ+) women may be at a heightened risk for experiencing marinization as a result of their intersecting identities compounding the effects of fatphobia. The purpose of this study was to use a qualitative, grounded theory approach to explore LGBTQ+ women's experiences of fatphobia, and how these experiences impact their romantic relationships. Four themes emerged from the data: (a) fatphobic is chronic and pervasive in the lives of fat, queer women, (b) fatphobic experiences begin in childhood and continue into adulthood, and are perpetrated by close family and friends, as well as strangers, (c) chronic experiences of fatphobia create negative mental and physical health outcomes for fat, queer women, and (d) intentional body work is used to help fat, queer women cope with and respond to chronic oppression. Suggestions for how healthcare workers and therapists can support fat, queer women engage in intentional body work are provided.

Key words: fatphobia, weight bias, LGBTQ+, romantic relationships, relationship satisfaction

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Thank you to my committee and to my participants for your time and attention to this project. I hope that this project helps people, and plants a seed that facilitates change in how healthcare workers and practitioners think about and work with people of size. Without your commitment and approval of this message it wouldn't be possible.

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CHAPTER 1

INTRODUCTION

Fatphobia is a relatively new and underexplored area of psychological research. The concept of fatphobia is described in the literature as a type of oppression or marginalization that a person experiences due to their body size, shape, or weight. Fatphobia impacts all fat people but seems to target fat women most severely due to societal pressures placed on women's bodies to be both thin and curvaceous (e.g., Becker, et al., 2010). Fatphobia is mentally and emotionally impactful, and it has been associated with low self-esteem, increased symptoms of depression and anxiety, and body image concerns (e.g., Wu & Berry, 2017; Himmelstein et al., 2018). Fatphobia is also physically impactful, because it has been associated with an increased risk for disordered eating and eating disorder diagnosis, high cortisol levels, and medical negligence (e.g., Friedman et al., 2017; Kinavey & Cool, 2019). From a social perspective, fatphobia can impact a person's dating life, relationship quality with family members and friends, and romantic relationship satisfaction (e.g., Carels, et al., 2020; Van den Brink, et al., 2018).

Historically, fatphobia is a form of oppression that is rooted in anti-Blackness and should be conceptualized as a result of White Supremacy (Strings, 2019). Much like sexism or racism, fatphobia can lead to discrimination and victimization (Munro, 2017). Munro (2017) conceptualized weight stigma through a microaggression framework to understand the ways in which the impacts of fatphobia, weight stigma, and weight microaggressions have mental and physical repercussions for fat individuals. Munro argued that, because of the potential for fatphobia to have a cumulative, life-stress model impact on the health and wellbeing of a person, a better understanding of the impact of fatphobia is needed within the field of psychology.

Fatphobia is disproportionally impactful. Particularly, women are at greater risk for experiencing fatphobia than men, due to societal beauty standards placed on women (e.g., Lunghurst, 2005). White-washed, Eurocentric standards of beauty have been societally constructed and are reflected in, among other things, the biased healthcare tool called the Body Mass Index (BMI), which leads to negative perceptions of women's full-figured, curvaceous bodies (Strings, 2019). The BMI is a healthcare tool created by a European mathematician who studied White men's bodies, and it was used to determine an ideal height to body weight or body fat ratio that is considered optimum for health (Nuttall, 2015). This tool was used by Western healthcare professionals to categorize bodies into "healthy" and "unhealthy" categories as a result of a person's body weight, body fat percentage, or body size. The utilization of BMI particularly impacts Black women, as it provides a basis for the medical field to categorize Black women's bodies, which tend to be curvier, as unhealthy (Strings, 2019). Fatphobia can also be associated with social class and wealth (e.g., Lunghurst, 2005). Wealthier people often have access to a steady source of food, and can afford healthy groceries, access to healthcare, nutrition information, and dietitians, and have more time and access to exercise.

Some healthcare professionals utilize the BMI tool as a justification for treating fat people poorly, neglecting their medical care, or fat shaming them (e.g., Strings, 2019). Whereas fatphobia is often cloaked by medical providers and society as a concern for a person's health, researchers have been able to identify that a person's body size and their health are not strongly correlated (Rinaldi, et al., 2016). Whether or not a fat person is unhealthy should not dictate their worth or determine whether or not they should be respected. The medical perspective on health has been the central perspective, and other perspectives (i.e. mental health, social health, person-centered view of health) have not been heard. This research paper intentionally de-centers the

traditional medical perspective while still considering the implications that the medical perspective have had on women. Instead, this paper will emphasize and center the Health At Every Size (HAES) model of health. Additionally, this paper is a feminist writing that adamantly discourages the policing of women's bodies. With current Roe v. Wade decisions, it is important to emphasize women's body autonomy and thus allow women the ability to make decisions for themselves and to encourage others to prioritize women's bodily autonomy despite perspective or opinion.

Fat women often experience microaggressions and other forms of oppression, such as discrimination, during healthcare visits (Pausé, 2014). In a study on medical fatphobia conducted by Pausé (2014), fat women consistently reported being told to lose weight before they would be treated by their doctors, or they were told that their symptoms are a result of their body weight rather than an actual medical condition. Some fat women experienced being excluded from surgical or medical health procedures, being told that they were too large to undergo surgery or were forced to lose weight before a medical procedure would be performed. Many fat women reported experiencing accessibility concerns in doctors' offices, such as not being able to have their blood pressure taken because the cuff did not fit, or being unable to fit on an exam table (Pausé, 2014). Medical researchers, who recognize that medical fatphobia is a health concern for fat women, have found that weight stigma, or experiences of marginalization that a person experiences due to their weight, is likely more harmful to a person's health than their weight or body size (Rinaldi, et al., 2016).

Fatphobia can be impactful in many different aspects of peoples' lives, including their romantic relationships (Long, 2020). Fatphobia has been associated with negative self-esteem and body image, which are both risk factors for relationship distress (Van den Brink, et al.,

2018). Fatphobia has also been associated with dating concerns, such as experiencing discrimination on dating apps, or experiencing microaggressions on dates (Taylor, 2020). According to Long (2020), romantic relationships contribute substantially to the overall happiness or satisfaction a person has with their life and can even influence mental and physical health. People in happy relationships report fewer mental health symptoms and lower rates of physical health concerns like high blood pressure, diabetes, and heart disease (e.g., Otis, et al., 2006; South & Krueger, 2013). Thus, psychologists should work to better understand how to help prevent or remedy relationship dissatisfaction in order to improve the physical and mental health of their clients. Understanding the effects of fatphobia on relationships can contribute to this mission.

Sexual satisfaction is a key component to overall relationship satisfaction for many couples. When asked to rate which components of a relationship are most important, people often rank sexual satisfaction at the top of the list (e.g., Byers, 2005; McNulty, Wenner, & Fisher, 2016). Experiences of fatphobia may impact the sexual health of fat individuals (Fields, et al., 2020). Internalized fatphobia has been shown to decrease a person's self-esteem, and self-esteem is one of the largest predictors of sexual health (Fields, et al., 2020). Therefore, there is reason to believe that internalized fatphobic beliefs may directly impact a person's self-esteem, which may in turn negatively impact fat peoples' sexual health.

Lesbian, gay, bisexual, queer, pansexual, and transgender (LGBTQ+) women may be at an even greater risk for experiencing fatphobia than straight women, as sexual minority women may be at a greater risk of oppression related to their intersecting marginalized identities related to sexual orientation and/or gender identity (Rice, 2014). Some scholars have argued that queer women are less likely to internalize expectations about femininity and appearance (e.g., Ludwig

& Brownell, 1999; Meyer et al., 2001). Some have even argued that queer women have immunity from weight stigma due to higher rates of body acceptance (e.g., French et al., 1996; Herzog et al., 1992; Share & Mintz, 2002). However, other researchers emphasized that women have the highest rates of eating disorders, and leaving queer women out of that discussion adds barriers to treatment and seeking support (Becker et al., 2010; Rice, 2014; Thompson, 1997). Rinaldi et al. (2016) suggested that fat queer women have a unique way of engaging in, being affected by, negotiating, and resisting weight body image expectations.

This review of the literature suggests that fatphobia influences LGBTQ+ women's relationships in unique ways. For instance, some LGBTQ+ women have expressed that they feel more comfortable with their bodies when in a relationship with other women, in which societal pressures about a woman's body are not enforced by a man (Ospina, 2017). Furthermore, some queer women have expressed that other women they date may better understand their bodies' imperfections.

However, the LGBTQ+ community has a long history of fatphobia. Han (2008) observed that phrases like "no fats, no femmes" were seen on dating profiles of LGBTQ+ people. This means that these phrases were still being routinely used less than 15 years ago. This stigma can still be observed within the queer community today, where gay men frequently endorse unrealistic body standards that focus on muscle growth and physical fitness (Han, 2008). Meanley et al. (2020) examined online dating app behaviors between LGBTQ+ individuals and found that 60% of their participants reported being the target of size-based discrimination. These researchers suggested that size related discrimination significantly impacted self-esteem for their participants. Weight based discrimination was also positively related to depressive symptoms for people of color (POC) in their study (Meanley, et al., 2020). Allison (2020) suggested that

LGBTQ+ women couples may experience greater amounts of internalized fatphobia than a straight couples, because women experience fatphobia at higher rates, and in these couples both partners are women. Allison (2020) conducted a qualitative study exploring experiences of queer fat femme women and nonbinary individuals and found that their experiences of dating often included experiences of rejection and fetishization as a result of their weight and/or body size. Their experiences were related to various negative outcomes including feelings of fear, undesirability, and failure, which the author suggested were a result of fatphobia.

This study will be focused on the lived experiences surrounding fatphobia and relationship satisfaction in plus-sized, fat, or larger bodied, queer, lesbian, gay, bisexual, and/or pansexual women who are in relationships with women. It is important to focus on this specific subpopulation of the LGBTQ+ community, as these individuals may be at greater risk for the adverse consequences of fatphobia. A qualitative Grounded Theory study will be conducted. I will recruit fat LGBTQ+ women in relationships to complete interviews focusing on the topic of fatphobic experiences and relationship quality. Purposive sampling strategies will be utilized to gather a diverse pool of participants with various racial, ethnic, age, ability status, and socioeconomic backgrounds. The objective of this qualitative study is to determine how fatphobia impacts fat LGBTQ+ women and their relationships. More specifically, this study will explore via semi-structured interviews these women’s experiences of fatphobic microaggressions, with particular questions to explore these women’s experiences of medical fatphobia. The interview will also be focused on how fatphobia and societal expectations about body size and shape impacts fat LGBTQ+ women’s self-esteem, self-conceptualization, and finally, their romantic relationships Gathering fat LGBTQ+ women’s perspectives should provide a richer understanding of fatphobia and the associated psychological, physical, and

social implications. Given that fatphobia is largely unexplored in the psychological literature, it is expected that theses participants' experiences will generate unique concepts and descriptors of the ways in which fatphobia impacts relationships for fat LGBTQ+ women. Grounded theory method also allows for the development of theoretical constructs or models, if such phenomena emerge from the data.

CHAPTER 2

REVIEW OF THE LITERATURE

Fatphobia

Fatphobia is the intense fear of, and discrimination against, fatness (Robinson & O'Rielly, 1993; Araújo, et al., 2018). Fatphobia is negatively impactful for most women, as research has indicated it can lead to mental health concerns such as decreased self-esteem and increased depression and anxiety symptoms, increased risk of stress related health concerns such as a high cortisol level, and increased risk of disordered eating (Wu & Berry, 2017). Fatphobia is believed to disproportionately affect women, where women are more likely to be shamed for being fat due to the unrealistic body standards society places on women (Becker, et al., 2010). Women also experience higher rates of fatphobia due to internalized misogyny, where women begin to project beliefs upon other women and themselves about how women should look and act (Rinaldi, et al., 2016). Rinaldi et al. (2016) argued that discussions of obesity and fatness reinforce cissexist and heteronormative body standards. These standards include prescribed ways bodies "should" look in order to be desired and celebrated.

Fatphobia and Anti-Blackness

Fatphobia has been around for generations and is thought to be a direct result of the internalization of racist beliefs about beauty (Strings, 2019). Sabrina Strings wrote *Fearing the Black Body*, a book about the historical roots of fatphobia as it relates to anti-Blackness and racism. Strings (2019) argued that, in the 16th century, thinness was reserved for the lower class, where thinness represented sickness or having lack of access to proper food and nutrition, and the desired body type full-figured and curvaceous, what might now be called Rubenesque. Soon after, European writers began to discuss the body shape and size of enslaved Southern African

women, using terms such as “grotesque,” “monstrous,” and “animalistic.” As these writings began to circulate through Europe, rich, White, Europeans began to strive for thinner bodies, and began equating thinness with wealth and beauty. “Fatness” began being understood as synonymous with “Blackness” and particularly, Black femininity, where Black women’s bodies were caricatured in magazines and movies. Saartjie Baartman, an enslaved African woman, was actually forced to participate in circus-type performances, depicted as a “freak” for her body shape and size (Strings, 2019). Over time, White Supremacy became sustained by ensuring that immigrants and African slaves were categorized as “non-ideal” and thus further racial and class distinctions were created (Strings, 2019).

Today, the “obesity epidemic” continues to target Black women, where Body Mass Index (BMI) is utilized to calculate obesity and is considered the pinnacle of health (Strings, 2019). The BMI is a tool that was created by Lambert Adolphe Jacques Quetelet, a Belgian mathematician (Nuttall, 2015). Using only White male participants, Quetelet created the BMI tool to measure obesity, which is now considered the gold standard for measuring obesity for people of all races, ethnicities, and genders (Nuttall, 2015). Strings (2019) argues that Black women are considered outcasts by medical professionals due to their size and are often medically neglected due to their BMIs. Strings (2019) observed, “without understanding how fatphobia emerged in response to slavery and in order to solidify whiteness as an embodied phenomenon, we cannot grasp how our contemporary obsession with thinness is rooted in anti-Blackness. The most current manifestation of institutionalized fatphobia around ‘obesity’ as a public health crisis is deeply reliant on the same ideologies that European race scientists drew on to construct fat as indicative of the laziness of body, mind, and spirit.” (Strings, 2019, p. 64).

Fatphobia and Classism

Not only is fatphobia tied to anti-Blackness and racism, it is also tied to classism as well (Longhurst, 2005; Hernandez & Pressler, 2014; Pan et al., 2015). Body shape has long been utilized as a tool to indicate social class and wealth. “For the bourgeois of the early nineteenth century, a robust figure graphically illustrated to others their wealth and prosperity,” (Craven & Constance, 1996, p. 30). Longhurst (2005) discussed fatphobia through a feminist, geographical lens, and argued that, in modern day, thinness is often tied to wealth and high social class, where wealthier individuals often have the money to pay for general practitioners, physical trainers, and nutritionists. Longhurst also observed that fatphobia is often cloaked in a concern for a person’s health, where health and weight are often discussed as synonyms. The author argued that fatness does not indicate unhealthiness, and thus discrimination based on body size is rooted in fatphobia rather than concern for a person’s health (Longhurst, 2005).

It appears that fatphobia is also related to class via childhood poverty. Using a sample of 3901 young adults born between 1980 and 1990 who completed the Young Adult file of the 1979 National Longitudinal Study of Youth, Hernadez & Pressler (2014) examined the relationship between body weight and household income. Using logistic regression models, the researchers found that acclimation of childhood poverty from prenatal through age 18 was linked to body weight. They further noted that socioeconomic status and body weight are inextricably linked for those of all races and genders. However, White, Black, and Hispanic young adult women who were exposed to childhood poverty at multiple points throughout their childhoods were the most affected. These researchers further explained that recurring exposure to childhood poverty increases the risk of being overweight, and that this effect is significantly higher for women than men regardless of race or ethnicity. One limitation to Hernandez & Pressler’s (2014) research is

that they were not able to explain why recurring exposure may increase the risk of being overweight for women, but not men. They suggested that young men may be more likely to engage in labor intensive jobs than young women, but this hypothesis was merely opinion based.

Pan et al. (2012) sampled 66,000 adults from 12 states in the United States in order to better understand the association between food insecurity and obesity. T-tests were utilized to compare means between groups of respondents, and a logistic regression was used to examine the association between food insecurity and obesity for those in the sample. The researchers found that the prevalence for obesity in the sample was 27.1% overall. However, for food secure adults in the sample, the prevalence of obesity was 25.2%, and for food insecure adults in the sample, the prevalence of obesity was 35.1%. Furthermore, food insecure adults had 32% increased odds of being obese compared to food secure adults. Food insecure adults in the sample had a higher prevalence of obesity rates in the following subpopulations: (a) adults less than 30 years old, (b) women, (c) non- Hispanic White Americans, (d) non-Hispanic Black Americans, and (e) people with a household income of less than $75,000/year (Pan, et al., 2012). While this study was cross-sectional in nature and thus causal relationships could not be determined, Pan et al. (2012) suggested that cyclical food restriction in food insecure individuals could be a cause for this significant difference in obesity rates. These researchers further suggested that cyclical food restriction (i.e., not eating when food is not available, and eating a lot when food is available) is associated with an increase in body fat, decrease in lean body muscle mass, and a quicker weight gain, where the body increases body fat storage in response to both actual food storage and perceived food insecurity.

Fatphobia and Health

Fatphobia and Physical Health. Himmelstein and colleagues (2015) observed that fatphobic beliefs and stigma have increased over the past decade. Discussions about fatness have mostly focused on concerns about body shape and size, which were often preceded or framed by concerns about obesity and health (Rinaldi, et al., 2016). Although it might seem reasonable to conclude that weight stigma would increase an individual's motivation to lose weight, researchers have argued that weight stigma, or fatphobia, actually negatively impacts a person's physical health (e.g., Himmelstein et al. 2015; Wu & Berry, 2017, Himmelstein et al., 2018). Himmelstein and colleagues (2015) studied 110 female undergraduate participants to better understand the effects of experimentally manipulated weight stigma on the stress responsive hypothalamic–pituitary–adrenal axis (HPA). The HPA is the area of the brain responsible for secreting cortisol, a hormone that is produced in response to stress and has been linked to weight gain in those with perpetually high cortisol levels in their blood (Himmelstein et al., 2015). Cortisol is responsible for increased appetite and fat storage as well. Participants who self-reported themselves as "heavy" experienced higher cortisol levels after the experiment. The researchers concluded that participants' perceptions of their own body weight moderated the effect of weight stigma on cortisol reactivity. That is, those that perceived themselves as heavier sustained higher cortisol levels after experiencing weight stigma. These researchers argued that there are physiological consequences that result from weight stigma which can result in negative health outcomes and higher perceived stress. Himmesltein and colleagues (2015) hypothesized that weight stigma can create a cycle, wherein stigma results in cortisol secretion, promoting weight gain and subsequently experiencing more stigma.

Wu and Berry (2017) conducted a meta-analysis of literature from the National Heart, Lung and Blood Institute that included 33 quantitative studies investigating the associations between weight stigma, physiological health, and psychological health outcomes in adults who were overweight or obese. The majority of participants across the studies were White (mean = 69.6%, SD 26.9%) and the mean age of participants across the studies was 44.6 years (SD 12.7). The researchers found that weight stigma was positively associated with obesity and diabetes risk, as well as other physiological health concerns such as increased cortisol level, oxidative stress level, and C-reactive protein level. These researchers also determined that the greater the weight stigma the participant endorsed, the worse the physiological health status, regardless of the measures of weight stigma or the actual weight of the individual. Of course, the limited racial and ethnic makeup of the samples decreases the generalizability of these findings. Furthermore, class or socioeconomic status was not discussed, which is linked to obesity. Nonetheless, Wu & Berry (2017) concluded that weight stigma does not actually motivate weight loss in overweight individuals, but further stigmatizes them and leads to an increased risk for adverse health outcomes.

Himmelstein and colleagues (2018) examined coping responses as mediators of the relationship between experienced weight stigma and health. A sample of 912 adults was generated from a national survey panel administered by Survey Sampling International. The participants in this sample identified as White (64.9%), Hispanic/Latino (15.8%), Black (13%), Asian (4.4%), or other (1.9%), and 53.9% Female, 40.33% Male. Information about LGBTQ+ identities were not discussed. Participants self-identified as overweight. These participants completed measures of stigma, stigma-specific coping responses, health indices including depressive symptoms, physical health, and psychological well-being, dieting frequency, and self-

esteem. Mediation models were tested for each health variable (i.e., depressive symptoms, physical health, psychological well-being, dieting frequency, and self-esteem). The researchers found that most participants reported weight stigma (88.9%), unfair treatment due to weight (56.1%), and discrimination based on weight (43.1%). Weight stigma in this sample was associated with poorer physical health as a result of maladaptive eating coping patterns. Men in the sample reported better physical health than women in the sample and reported engaging in coping strategies less frequently. Himmelstein and colleagues (2018) interpreted their results to mean that negative coping responses, mainly maladaptive eating, may explain the relationship between experienced weight stigma and negative health consequences. However, this study is cross-sectional and correlational, so causality cannot be assessed.

Fatphobia and Mental Health. Before 2015, fatphobia was predominately understood as a risk factor for anorexia nervosa within the realm of psychology, and thus was mostly discussed in relation to disordered eating and weight related concerns for clients with eating disorders. Now, psychologists have a better awareness and understanding of fatphobia, recognizing that it is a type of oppression or marginalization that a person experiences due to their body size (Puhl & Brownell, 2020). Much like sexism or racism, fatphobia can lead to discrimination and victimization (Munro, 2017). Munro (2017) conceptualized weight stigma through a microaggression framework to understand the ways in which the impact of fatphobia, weight stigma, and weight microaggressions have mental health repercussions for fat folks. Because of the potential for fatphobia to have a cumulative, life-stress model impact on the mental health and well-being of a person, a better understanding of the impact of fatphobia is needed within the field of psychology (Munro, 2017).

Researchers within the medical field have suggested that fatphobia, often referred to in the medical field as weight stigma, is associated with negative mental health outcomes (e.g., Friedman et al., 2017; Kinavey & Cool, 2019). Friedman and colleagues (2008) evaluated the association between the number of weight-based stigmatization experiences within the past month and psychological functioning, including binge eating behaviors, with a sample of individuals seeking weight loss surgery. A sample of 94 obese adults (25 men and 69 women), who were in the process of being approved for weight loss surgery, were given a clinical interview. Of this sample, 81% of the participants were White, and 57% of the sample were married. The Stigmatizing Situations Inventory (SSI), Beck Depression Inventory, Rosenberg self-esteem scale, and Symptoms Checklist-90-R (SCL-90-R) were completed by each participant before engaging in a clinical interview with a researcher. Using both hierarchical regressions and logistic regressions, the researchers found that recent experiences of weight stigma was associated with a diagnosis of binge eating disorder for individuals in the sample. Furthermore, frequent experiences of weight stigma were associated with lower self-reported self-esteem and higher self-reported depression and anxiety symptoms (Friedman et al., 2008). This study was the first of its kind to reveal that phobic anxiety and experiences of weight stigma are positively associated. Phobic anxiety as measured by the SCL-90-R is associated with feeling afraid of or avoiding travel, feeling nervous or anxious in crowds, avoiding certain things or places due to fear of anxiety, and feeling more self-conscious around others. The researchers concluded that phobic anxiety is learned and maintained by repeated exposure to weight stigma in overweight individuals.

Himmelstein and colleagues (2018), who conducted research on coping responses as mediators of the relationship between experienced weight stigma and physical health, also

examined the impact of coping responses on weight stigma and mental health. These researchers found that weight stigma was associated with increased depressive symptoms and dieting behavior. Weight stigma was also associated with low self-reported self-esteem for individuals in the sample (Himmelstein et al., 2018). Puhl and colleagues (2020) also found that weight stigma was associated with poorer body image and higher body dissatisfaction for many adult individuals. Furthermore, for those seeking weight loss treatment, frequency of experienced weight stigma was positively associated with poor body image. Of course, low self-esteem is a risk factor for many mental health diagnoses, including Major Depressive Disorder and Social Anxiety Disorder (e.g., Henriksen, et al. 2017).

Health At Every Size (HAES) is a health and culture related movement created by the Association of Size Diversity and Health in 2003 and made popular in mainstream culture by Dr. Lindo Bacon. This movement sparked out of the understanding that diet culture and fatphobia are harmful for fat individuals (Bombak, 2017). The HAES dieticians, psychologists, and activists reject the idea that weight, BMI, and/or body size are indicators of health (Robinson, Bacon, & O'Reilly, 1993). The HAES lifestyle rejects diet culture and suggests that there is no scientific evidence that supports that diets work. The HAES approach instead suggests mindful eating practices (i.e., eating when hungry, stopping when full), disregarding the idea that some foods are 'good' and some are 'bad', and adding enjoyable forms of exercise when appropriate. The US Department of Agriculture (USDA) conducted a study in 2006 to compare HAES lifestyle choices to dieting in order to compare weight loss and health impacts. The USDA found that after 2 years, the majority of participants who had been put on a diet had lost 20lbs but gained back all 20lbs within the 2 year study. The HAES group weighed approximately the same as the diet group and had lost a statistically similar amount of weight. However, the HAES group

of participants had significantly better blood pressure, cholesterol, and self-reported higher levels of weekly exercise than the diet group (US Department of Agriculture, 2006). Based on this study, HAES clinicians reject diet culture and believe that diets do not work (Bacon, 2008). Some medical providers are beginning to adopt the HAES viewpoint as additional research shows HAES leads to chronic-disease prevention and improves overall wellbeing (Bombak, 2017).

Kinavey and Cool (2019) discussed anti-fat bias in the context of therapy, recommending that mental health practitioners (MHP) should shift to a weight-inclusive mindset. They suggest that MHPs should become familiar with the Health at Every Size approach, which they argued is grounded in a social justice and multicultural framework. They observed that some clients avoid seeking mental health care as a result of weight stigma and size-based microaggressions. Kinavey and Cool noted that this is a result of therapists assuming fatness is an indicator of trauma or believing that healing trauma will result in weight loss for their clients. These authors argued that, "It is our [therapists'] job to be aware of the internalized weight-bias we carry into our therapy offices everyday. In order to serve our clients, we must center the real work of liberation and justice above our own personal aesthetic, comfort, and worldview about body size," (Kinavey & Cool, 2019, p. 129).

Internalized Fatphobia

Internalized fatphobia is the degree to which one applies negative social or cultural beliefs about body weight onto themselves (Durso, et al., 2012). An example of internalized fatphobia might be when a person begins to believe they are unattractive due to their body size. Pearl and Puhl (2018) argued for the existence of strong, negative relationships between internalized fatphobia and negative mental health outcomes.

Using Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines for systematic reviews, Pearl and Puhl (2018) conducted a meta-analysis where 74 articles were included to better understand the relationship between weight bias internalized (WBI) and mental and physical health. The researchers defined weight bias as, “a prejudicial attitude that is rooted in negative stereotypes, including views that people with obesity are lazy, incompetent and lack willpower.” (Pearl & Puhl, 2018, p. 1142). These researchers found that WBI was positively associated with depressive symptoms in 28 of the 30 studies, with 25 studies yielding moderate to strong correlations (r = 0.30-0.50). Generally, these correlations were stronger for women than men. In this study, WBI was also positively correlated with increased anxiety symptoms in 11 studies. Of those 11 studies, self-esteem was negatively correlated with WBI, indicating that higher levels of internalized fatphobia were related to lower levels of self-esteem for the individuals in the sample (Pearl & Puhl, 2018). Participants who endorsed high levels of WBI also endorsed high levels of psychological distress, including brooding, emotion dysregulation, rumination, and dissociative experiences. Body dissatisfaction and body image concerns were also positively correlated with high levels of WBI. This meta-analysis, focusing on the exploration of weight bias internalization and mental health, can be interpreted by readers to suggest that strong, negative relationships between WBI and mental health outcomes are endorsed by many participants.

Summary: Fatphobia

The above research illustrates that health and body size are not synonymous (Rinaldi, et al., 2016). Weight related stigma can be traced back to anti-blackness and racist beliefs that European, White bodies and associated thinness is “ideal” (Strings, 2019). Tools utilized in healthcare settings to determine health, such as the BMI, have racist origins and further

perpetuate stigma, shame, and limit access to adequate healthcare for fat individuals (Strings, 2019; Nuttall, 2015). Weight stigma negatively impacts fat individual's mental and physical health (i.g. Himmelstein et al. 2015; Wu & Berry, 2017; Friedman et al., 2017; Kinavey & Cool, 2019). Health At Every Size clinicians argue that the impact of weight stigma can be more harmful to fat individuals than the medical impacts of being overweight (Kinavey & Cool, 2019).

Medical research is currently the backbone of fatphobia research, where medical practitioners are conducting weight bias related research and psychology has a dearth of information on this topic. This is problematic for psychological researchers because medical research tends to focus on the medical model, whereas psychologists often conduct research from a wellness model perspective (Armentrout, 1993). Discussion about the negative impact of fatphobia on mental health within the psychology community may help to spur research in this area. Correlational studies that target minority populations, such as BIPOC and LGBTQ+ folks are in high demand at this time. Understanding the negative mental and physical health impacts that fatphobia has on fat individuals makes it imperative that psychologists give this type of oppression and marginalization their attention (APA, 2017). Psychologists utilize the APA multicultural guidelines which state that psychologists should work to identify areas of marginalization and oppression, and work to prevent and intervene within these systems (APA, 2017).

Fatphobia within the LGBTQ+ Community

The LGBTQ+ community has been described by its members as being a place one can show up authentically, be oneself, explore one's identities outside of a cisheteronormative lens, and find like-minded communities (Riggle, et al., 2008). However, for some particular individuals, the LGBTQ+ community can be a place where, while expecting to find community

and open-mindedness, they experience discrimination and prejudice (McGrady, 2006). For fat LGBTQ+ people, the LGBTQ+ community has historically been, and continues to be, unwelcoming. Particularly, online dating, gay bars, and PRIDE festivals have been spaces in which fat LGBTQ+ people face discrimination and prejudice within their own community (Meanley et al., 2020).

Meanley and colleagues (2020) obtained cross-sectional data from a survey regarding HIV-prevention for 172 single young men who have sex with men who were seeking partners online. These men were given a survey that included the Everyday Discrimination Scale, Rosenberg's Society and the Adolescent Self-Image Scale, and Center for Epidemiologic Studies of Depression Scale (CES-D 10), and participated in a semi-structured interview. Using hierarchical regression analysis, Meanley and colleagues found that over 60% of the sample reported appearance or weight-based sexual discrimination when dating online, which was positively associated with low self-esteem for the individuals in the sample. Experiences of weight-based discrimination were also positively associated with depression symptoms for individuals in the sample.

Intersectionality Theory, LGBTQ+ Identity, and Fatphobia

Considering the previously presented Meanley and colleagues' (2020) study, it is hard to know how systems of oppression impacted these men who were both queer and experiencing weight-based stigma. Did they experience increased levels of depression and lower self-esteem because of weight stigma or because of homophobic or transphobic discrimination, or some combination thereof? Intersectionality theorists would argue the cumulative experience of being gay or queer and fat cannot be parsed out. Thus, researchers cannot pinpoint which aspects of these individuals' identities may be associated with depression and self-esteem and instead

should assume that it is the cumulative, interwoven experience of being both queer and fat are interacting with systems of oppression for these individuals. I will continue to utilize an intersectionality framework throughout this dissertation to explore and seek to better understand the experiences of being queer and fat.

According to intersectionality theory, social categories such as race, class, body size, gender, or sexual orientation are interlocking and overlapping, and therefore systems of discrimination cannot be pulled apart and dissected independently but must be understood as interdependent (Crenshaw, 1989). The cumulative experience of being fat and queer cannot be dissected independently but must be understood as a lifetime of cumulative and unique experiences, in which that individual will certainly experience unique types of discrimination and prejudice within a fatphobic, cisheteronormative society. For instance, McGrady (2016) utilized a grounded theory methodology to interview fat, gay men who identified as part of the 'bear' community. The bear community is a sect of the LGBTQ+ community for hairy, heavy-set, gay, queer, or bisexual men.

Men in the McGrady (2016) sample identified as White (15), Black (4), and Latino (2) and were between the ages of 23 and 55. McGrady found that bears experience both discrimination in relation to their sexual orientation but also their weight. Most bears within the sample indicated that their community was a place of acceptance and comfort to be themselves [larger bodied]. Some of these men talked about pageants where bears will flaunt their hairy chests, muscles, and stomachs. Most of the men surveyed described the LGBTQ+ community, and particularly experiences at gay bars or PRIDE festivals, as stigmatizing or shaming in relation to their size or weight. One bear described their experience of the bear community as a resistance of the body ideals of gay culture. These experiences of bears within the LGBTQ+

community illustrate how not even a community aimed at being openminded and free to express oneself is absent of discrimination and stereotypes (McGrady, 2016).

Fatphobia, Body Satisfaction, and Gender

Societal Expectations of Femininity and The Male Gaze. Ludwig & Brownell (1999) examined gender expression (i.e., masculine, feminine, androgynous) and weight stigma for lesbian women. Lesbian and bisexual women ages 18-55 (N = 188) were surveyed. Using factor analysis, the researchers found that women who identified as feminine expressed less body satisfaction than did women who identified as androgynous or masculine. It is important to consider the implications of this finding that femininity was connected with body dissatisfaction. Some authors have argued that individuals who are attracted to men are more likely to experience less body satisfaction and internalized fatphobia beliefs (e.g., Pitman, 2000, Walters, 2011), citing objectification theory (Fredrickson & Roberts, 1997), in which it is posited that the male gaze is internalized, and rigid expectations and standards of the female body are solidified via reinforcement by men. Calogero (2004) surveyed 104 undergraduate women who were predominantly White, heterosexual, and considered themselves to be within an underweight weight range. Participants completed the Self-Objectification Questionnaire, Body Shame Questionnaire, Social Physique Anxiety Scale, and Dietary Intent Scale. Then, participants were asked to anticipate male or female gaze and rate their responses to a series of questions. Participants reported significantly greater levels of body shame and social physique anxiety when anticipating a male gaze versus a female gaze (Calogero, 2004).

Hepp and colleagues (2005) hypothesized that the idea of male gaze and how it impacts women's body satisfaction would not be limited to just heterosexual couples. Therefore, these researchers conducted a study on feminine vs. masculine ideals and body satisfaction in same-

sex women's relationships. Hepp and colleagues (2005) found that women in their study who rejected traditional feminine standards, such as masculine lesbians, reported that they were more satisfied with their bodies over the course of their lives than feminine lesbian women in the study, who reported that they felt they were supposed to value femininity and heteronormative ideals of body image (Hepp et al., 2005). Based on these data, Hepp and colleagues (2005) hypothesized that masculine lesbian women may be more satisfied with their bodies due to rejecting traditional societal expectations that are placed on women and femininity.

Partner's Impact on Body Satisfaction. Markey and Markey (2013) hypothesized that people's partners may impact their body satisfaction. They conducted a survey study of 72 female same-sex couples who were predominately White and middle class. Participants were given the Weight Concerns Scale, and using the Actor–Partner Interdependence Model, partner comparisons and weight concerns were calculated. Overall, women who identified as fat who had partners who identified as thin reported the highest levels of body dissatisfaction and concerns with their weight (Markey & Markey, 2013). The researchers concluded that people's partners have some influence on body satisfaction, particularly for women in relationships with women.

Rothblum (2002) hypothesized that women who date men (i.g. heterosexual women, bisexual women, pansexual women) are more focused on appearance and thus would be more prone to body dissatisfaction. Yean et al. (2013) found that women who primarily or solely dated women were less likely to internalize societal expectations about body weight than women who primarily or solely dated men. However, lesbian and bisexual women in the study reported that they were equally dissatisfied with their bodies compared to heterosexual women. Yean and colleagues (2013) argued that lesbian and bisexual women may be caught between expectations

of mainstream, heterosexual culture and lesbian or feminist culture expectations to reject heterosexual norms.

According to Kelly (2007), feminist ideologies about body size include the tendency to reject heteronormative culture and ideals, which can sometimes be referred to as a rejection of the male gaze. Kelly (2007) argued that the majority of women who reject heteronormativity are lesbian, bisexual, gay, or queer. This rejection of heteronormative culture and ideals usually includes questioning practices or creating new traditions around body related concerns such as weight and weight distribution, eating practices, hair grooming practices, makeup and hygiene related tasks, and personal clothing style (Kelly, 2007).

Fatphobia and Eating Disorders for LGBTQ+ People

Guille & Chrisler (1999) argued that feminist ideologies, which lesbian, bisexual, gay, and queer women are most likely to endorse, can be used to explain increases in disordered eating practices for LGBTQ+ folks. Other researchers such as Panza and colleagues (2020) argued that increased risk for eating disorders is likely due to unique experiences of oppression and discrimination that fat LGBTQ+ people face. This belief stems from a multicultural approach which recognizes the direct impact of systems of oppression on individuals and considers the impact of the minority stress model created by Meyer in 2003 (Panza, et al., 2020). In order to test this hypothesis, Panza and colleagues interviewed 55 sexual minority women between the ages of 18 and 66 who identified as fat. Participants were predominantly cisgender (96%), and they identified as bisexual (62%), lesbian (33%), and queer (5%). These participants responded to five prompts about dysregulated eating practices, such as overeating and binge eating. Panza et al. (2020) found that women with higher reported internalized homophobia were more likely to engage in binge eating or disordered eating behaviors. Women who reported

higher levels of internalized fatphobia reported higher levels of disordered eating. Women who reported experiencing more instances of weight-based discrimination also reported higher levels of disordered eating. These researchers concluded that minority stress experiences related to gender identity, sexual orientation, and body size increase sexual minority women's likelihood to engage in disordered eating behaviors, although causational claims could not be made due to the correlational nature of the data collected (Panza, et al., 2020).

Foster-Gimbel and Engeln (2016) conducted a study to explore experiences of antifat bias among gay men and resulting body image concerns. A sample of 215 gay men ages 18-75 was surveyed. Participants identified as White (73%), Hispanic (8%), Multiracial (7%), Black (6%), Asian (4%), and Native American (2%). They completed the Body Dissatisfaction Scale of the Eating Disorder Inventory, Drive for Muscularity Scale, and the Eating Attitudes Test. Participants were also provided with scenarios about dating and asked to answer questions about each scenario. Over one third of the gay men in the sample reported having experienced anti-fat bias, with the most common type of bias being rejection from a potential romantic partner on an online dating site. Gay men reported that they believed an overweight man would be ignored or mocked if he pursued a potential romantic partner. These authors found that the gay men in the sample's perceptions of their body weight and potential attractiveness to romantic partners contributed to the likelihood that these gay men would experience an eating disorder (Foster-Gimbel & Engeln, 2016).

Researchers Carlat and colleagues estimated that about 30% of gay men meet criteria for an eating disorder (Carlat et al, 1997). Carlat and colleagues (1997) surveyed 135 males with eating disorders and found that 42% of the men in this sample identified as gay or bisexual. This finding is similar to other studies that look at eating disorder prevalence among gay men (e.g.,

Simon et al, 2020; Nagata et al., 2020). Strong and colleagues (2000) collected a sample of 412 people ages 18-30 and asked these participants to disclose their sexual orientation. Strong and colleagues found that gay men and heterosexual women in the study were more likely to report disordered eating, eating disorder symptoms, and body image concerns than were lesbian women, and that heterosexual men were least likely to report these symptoms.

Lesbian women being less likely to report disordered eating than heterosexual women is impactful because in 2008, Guille & Chrysler argued that feminist ideals act as a protective function against eating disorders in sexual minority women. Strong and colleagues' (2000) study seem to indicate that lesbian women do experience less disordered eating symptoms than gay men and heterosexual women. Guille and Chrysler suggested that this is a direct result of lesbian women's tendency to internalize feminist beliefs and practices. This could mean that women in relationships with women are less likely to experience disordered eating because of a rejection of heteronormative ideals (Guille & Chrysler, 2008).

In contrast, other researchers have found that LGBTQ+ men and women are more likely to experience disordered eating behaviors than heterosexual men and women (Nagata, et al., 2020). In 2020, Simon and colleagues conducted a study to examine prevalence rates of disordered eating behavior in LGBTQ+ individuals compared to cisgender, heterosexual individuals. A total of n = 13,906 college students from a Minnesota university were given the College Student Health Survey which included questions about eating practices, disordered eating, and sexual and gender identity. Adjusted logistic regressions were used to test the association between gender identity, sexual orientation, and disordered eating behaviors. Simon and colleagues found that sexual minority individuals reported the highest levels of disordered eating behavior compared to cisgender and transgender heterosexual individuals. Bisexual

individuals in the study reported the highest rates of disordered eating of any LGBTQ+ group (Simon et al., 2020).

Summary: Fatphobia within the LGBTQ+ Community

These studies illustrated how LGBTQ+ people, and particularly LGBTQ+ individuals who date men, may be at high risk for feeling dissatisfied with their bodies and experiencing disordered eating (e.g., Strong, et al., 2000; Calogero, 2004; Panza, et al., 2020). Furthermore, LGBTQ+ people, and particularly bisexual individuals, seem to experience higher rates of eating disorders and disordered eating than do heterosexual individuals (i.g. Nagata et al., 2020; Simon et al., 2020). Some researchers have argued that feminist ideals may help to mitigate or relieve some of the impact of minority stress on disordered eating behaviors for sexual minority women (e.g., Guille & Chrysler, 2008). Due to limited research in this area, and the limitations of survey methodology, further studies will need to be conducted to determine whether or not adherence to feminist ideals actually moderates the relationship between minority stress and disordered eating in LGBTQ+ individuals. For now, it is safe to assume that minority stress and the impacts of oppression do contribute to the higher prevalence of disordered eating and diagnosed eating disorders in LGBTQ+ populations.

These reviewed studies have showcased that it is also possible that people’s partners can impact their overall body satisfaction (Markey & Markey, 2013). In particular, fat LGBTQ+ individuals with thin partners may report higher rates of disordered eating or body satisfaction than fat LGBTQ+ individuals with fat partners (Markey & Markey, 2013). It is hypothesized that body comparison between partners may explain some of the reported dissatisfaction (Markey & Markey, 2013). Gender and gender expression may also be related to disordered eating or body satisfaction. LGBTQ+ women who express their gender through femininity may be at greater

risk of disordered eating or body dissatisfaction than LGBTQ+ women express their gender in more masculine ways (Ludwig & Brownell, 1999). This research makes it clear that gender expression, particularly adherence to femininity, puts LGBTQ+ women at an increased risk for disordered eating. Many researchers argue that societal expectations about femininity, and adherence to cisheteronormative ideals, can be harmful to women and negatively impact their body satisfaction (i.g. Kelly, 2007; Rothblum, 2002). Limitations of correlational studies impact our ability to make causal claims about gender expression's impact on LGBTQ+ body satisfaction. Further research, particularly studies focused on causal models, could be conducted to test these hypotheses.

Intersectionality theory may be a way that researchers can begin to understand the interlocking and cumulative impacts of fatphobia, homophobia, and sexism for fat, queer folks (Crenshaw, 1989). For fat LGBTQ+ folks, the unique experience of facing discrimination for being both queer and fat within a cisheteronormative society, and not actually being able to find solstice within their community (LGBTQ+ community) because of anti-fat bias, is just one example in which these individuals' identities and systems of oppression that impact them cannot be parsed out. It is important to understand that there are complex systems of oppression impacting queer women that cannot be simply understood. Eap et. al. (2010) argued that in order to better understand these complex systems, researchers should focus on smaller sects of particular groups and take an idiographic approach to better understand the unique experiences of minority individuals. This study will be focused on one sect of the LGBTQ+ community, LGBTQ+ women, and one aspect of their experience, weight discrimination, in order to gain a more nuanced and specific understanding.

Fatphobia's Impact on LGBTQ+ Women's Body Image, Relationship Satisfaction, and Sexual Health

Fatphobia negatively impacts women's understanding of and relationship to their bodies. Individuals seem to internalize fatphobic messages from society about their bodies, specifically about what is a normal body weight and size, and about what is attractive. For instance, in 2021 a chart-topping song was released called Body by Megan Thee Stallion. This song includes lyrics such as "Body crazy, curvy, wavy, big titties, lil' waist," (Megan Thee Stallion, 2021, Good News Album, track number 8). Although this song is catchy and was intended to bring body autonomy and power back to women, it also sends explicit messages to society, and particularly women and girls, about what their bodies should look like in order to be attractive (i.e., be curvy, have large breasts, have a small waist). Other societal messages promote thinness, smallness, and petiteness, and are targeted at women via television, radio, and social media. Societal beliefs, social interactions centering body image, social comparison, and media consumption are factors that contribute to what women believe is the attractive body type. This conceptualization of women's body standards is thus internalized and can lead to negative body image (Levy, et al., 2021).

Fatphobia, Media, and Body Image for Women

A lot of empirical attention has been given to the study of media's impact on body image. A full review of the literature on the media's impact on body image is beyond the scope of this dissertation. Ferguson (2018) provided a thoughtful and comprehensive review of the literature, concluding that psychologists' understanding of the media's impact on body image is far more nuanced and complicated than previously understood. The author argued that the media's effect on body image is caused by socialization, peer interaction, and mate attraction, and the media

upholds and perpetuates these fatphobic beliefs rather than causes them. In this section, I will review a few recent examples of research on body image and media that are directly relevant to this study.

In 2000, Lavine published a literature review on media and body image. Lavine reported that, after reviewing the current literature, there were a few common themes or conclusions that could be made, (a) a women's life long project was to be beautiful, (b) magazines and newspapers influenced women to want a slender body, and (c) most women believe they are not good enough, skinny enough, or beautiful enough. Research in the early 2000s pinpointed mass media as the root cause of poor body image for women, claiming that the more women consumed body related media, the worse their body satisfaction would become (Lavine, 2000). These correlational underpinnings however do not imply that media causes body dissatisfaction, but instead that there is some relationship between these two constructs (Ferguson, 2018).

Researchers in mass communication and media marketing began to study the impacts of media on women and body image as well. Holstrom (2004), a broadcast journalist, conducted a meta-analysis of the literature on media and body image. The author concluded that media did not cause negative body image for women, but instead media caused unrealistic expectations of an ideal body. This expectation, or belief about an ideal body, was instead considered the cause of body dissatisfaction for women who consumed mass media (Holstrom, 2004). This conceptualization of media as an influence on body expectations made room for Levine to continue his research. Levine and Murnen (2009) conducted a critical review of the literature, focusing on long term, longitudinal studies of mass media and body image. They found that engagement with mass media is a risk factor for negative body image rather than the cause of it.

These researchers argued that women should be taught to be critical consumers of the media as an intervention to prevent body dissatisfaction (Levine & Murnen, 2009).

McLean and colleagues (2016) conducted a study to test Levine and Murnen's (2009) theory that media literacy could be used as a prevention effort to mitigate the effects of the media's impact on body image for women. McLean and colleagues (2016) recruited 246 Australian adolescent girls, average age of 13, and asked them to review body image related media and then rate their feelings about their bodies. This task was used to create a baseline score for each participant. Then, the participants were taught about media literacy and participated in a several hour session where they were taught to be critical consumers of media. They were then asked to view the same images and rate how they felt about their bodies. The pre-test and post-test scores were compared using an ANOVA. These researchers found that the participants in the study were significantly less satisfied with their appearance before learning about media literacy as compared to after. McLean and colleagues (2016) concluded that media literacy was a useful tool for mitigating the effect of media on body image for women.

Ferguson (2018) reviewed decades of research on media and body image and concluded that simply equating the association between media and body image as causation was not sufficient. Ferguson (2018) argued that the relationship between media and body image is nuanced and complex. Ferguson argued that media consumption is not actually the cause of negative body image, but a way in which the true causes of negative body image are upheld and distributed through society. Ferguson believes that the real causes of negative body image include social comparison, genetic risk, perceived mate value, and societal and cultural beliefs and expectations about women's bodies. The media seems to work as an agent that upholds and

disseminates these beliefs and expectations, rather than the cause of these beliefs and expectations.

Savoy and Boxer (2020) hypothesized that weight-bias media changed people's attitudes about the ideal body type and thus perpetuate discrimination, particularly fatphobia. These researchers provided example examples of weight-bias media, including stigmatization of fat characters on television or movies, discussion of body satisfaction, ideal weight, and diet-talk on reality TV shows, or celebrity endorsements of weight loss or dieting. These researchers argued that weight-based discrimination is a more acceptable form of discrimination in modern society than other commonly discussed forms of discrimination, such as racism or sexism. One overly simplified explanation for weight bias is that it may be seen as a more acceptable form of discrimination because of medical pressures to achieve thinness in order to achieve healthiness, where weight bias can be construed as concern for a person's health rather than as a form of discrimination. Due to the social acceptability of weight bias, these researchers argued that the frequency of weight discrimination in the media is very high.

In order to assess the impact of weight discrimination in the media, Savoy and Boxer (2020) showed 101 participants various segments of media, some that showcased weight discrimination (experimental group) and some that did not (control group). Participants were asked to describe their body satisfaction before and after viewing the video, using a Likert-type question. Attitudes about the media were also assessed after watching the various clips. The researchers conducted two ANCOVAs and found that there was a significant pre-post change in body satisfaction media screening for participants in the experimental group (i.e., decrease in body satisfaction), but no significant change was found for participants in the control group. The researchers also found that participants who identified as fat actually experienced higher body

satisfaction after viewing negative media than did participants who did not identify as fat. Participants who did not identify as fat reported lowered body satisfaction scores after viewing the media. These researchers interpreted their findings to suggest that the positive change in body satisfaction for self-reported fat people was due to an unexpected positive coping effect of viewing fatphobic media (Savoy & Boxer, 2020). These researchers found that, for participants in this study, seeing people who look like themselves in the media was considered affirming and validating. Therefore, media was not actually associated with body dissatisfaction for the plus-size women in this study This unexpected finding could be the result of fat individuals finding it affirming to see people who look like them on television or in movies. This conclusion is in support of Ferguson's argument that media is not the cause of body dissatisfaction, but rather media upholds societal beliefs about the ideal body.

Munsch and colleagues (2021) hypothesized that thin-image ideals do negatively impact women's body satisfaction. In order to test this theory, a group of 231 women from Europe were studied, and all were shown images of women with thin bodies that promoted thin-image ideals (e.g., words with fatphobic phrases, pro-diet posters). These women were primarily White, cisgender, heterosexual, and had a mean age of 22. These participants reported significantly less body image satisfaction after viewing pictures with thin ideals as compared to their self-reported body satisfaction after viewing neutral images of nature. Women with eating disorders reported even higher levels of dissatisfaction with their bodies as compared to women without eating disorders. Munsch and colleagues (2021) concluded that women in their study, and especially those with eating disorders, were susceptible to negative media messages about body image. It is important, however, to view these findings through a critical lens. Participants in this study were relatively homogenous and do not represent the overall population of individuals. Additionally, it

is possible that the actual cause of lessened body satisfaction was a result of social comparison between the participant and the women in the media, rather than the media itself. Ferguson (2018) argued that media is less of a contributing factor to body dissatisfaction than social comparison is.

Levy and colleagues (2021) wanted to test the relationship between weight bias internalization (i.e., negative self-beliefs about weight) and mental health outcomes such as body dissatisfaction. A sample of 175 Canadian adults completed the scales related to internalized body image and body satisfaction. A linear regression was conducted to assess the relationship between internalized weight bias and body satisfaction. A negative correlation of -0.70 was found, and researchers determined that, for participants in this study, as their internalized weight bias increased, their body satisfaction decreased. These findings suggest that people whom have internalized negative messages about their bodies may be less satisfied with their bodies. This conclusion is in support of Ferguson's (2018) observation that internalization of societal or cultural beliefs cause negative body image for women. Furthermore, women in this study reported significantly higher weight bias internalization scores than men and reported lower body satisfaction overall. These findings can be interpreted to suggest that women may be more susceptible to internalizing weight related stigma as compared to men. Another conclusion is that women may be more likely to experience weight bias than men. It is likely that both are true.

Fatphobia, Body Image, Relationship Satisfaction, and Sexual Health

Body image and relationship satisfaction have a direct, positive relationship for women, where as body satisfaction decreases, relationship satisfaction decreases, and vice versa (Razmus, 2019). Blais and colleagues (2019) found that for female service members and veterans, those with eating disorders reported lower levels of physical intimacy and sexual

relationship satisfaction due to avoidance of physical contact and intimacy. A sample of 479 female service members and veterans currently in a relationship were recruited and surveyed. These participants completed scales related to eating concerns, body satisfaction, and relationship satisfaction, as well as a demographics questionnaire. A linear regression analysis was conducted, and these researchers found that relationship satisfaction was negatively associated with disordered eating behavior with a medium effect size, and positively associated with sexual satisfaction with a large effect size. Blais and colleagues (2019) argued that family systems theory explains this association, where disordered eating can be understood as a stressor on the family system, which in this case is the relationship. These researchers argued that disordered eating behaviors led to partner distancing, which leads to fewer experiences of physical intimacy, which leads to lower self-reported sexual satisfaction.

Walters et al. (2019) surveyed 244 women in relationships to assess for relationship quality, body appreciation, and sexual functioning. Relationship researchers tend to report on sexual functioning when discussing relationship satisfaction, as sexual health in relationships is typically considered important to most couples (Gabb, 2019). Participants were primarily White, British, heterosexual, college students. These researchers found that participants self-reported body appreciation was directly related to perceived partner appreciation of the women's body. Sexual functioning was also associated with body appreciation for these women. Similarly, Van den Brink and colleagues (2018) surveyed 151 Dutch couples in order to assess for body image, sexual satisfaction, and relationship quality. Using an actor-partner interdependence model, these researchers found that individuals with higher levels of body image report greater sexual satisfaction, which in-turn is associated with greater relationship satisfaction. Overall, these

studies indicate that people with higher body satisfaction may experience greater sexual satisfaction in their relationships, which is positively correlated with relationship satisfaction.

Carels and colleges (2020) recruited a sample of 209 married, heterosexual wives in order to gain a greater understanding about their experiences of weight bias, and how these experiences impact their marriages. Surveys were used to assess internalized weight bias (IWB), weight-related concerns, wives' perceived husbands' weight-related comments, wives' perceived mate value, psychological distress, and relationship satisfaction. The sample consisted of primarily White (77%), presumably cisgender women as no gender identity categories were reported, with an average age of 49, and an average marriage length of 20 years. Participants were given the brief measures that assessed relationship satisfaction, sexual intimacy, depression symptoms, and self-esteem. Four structural equation models (SEM) were produced for the four outcome variables, which were marital satisfaction, sexual intimacy, depression, and self-esteem. These researchers hypothesized that marital satisfaction and sexual intimacy would be directly correlated, marital satisfaction and sexual intimacy would be inversely associated with depression and self-esteem, and that depression and self-esteem would be inversely correlated with one another.

Wives who reported that their husbands often commented on their weight, or who perceived that their husbands did not like their body weight, indicated via self-report measures that they did not believe they met their husbands body ideals, and reported higher levels of unattractiveness, body criticism, and lower self-esteem (Carels et al., 2020). These wives reported greater concerns about their marriage ending than did wives who reported low levels of husband criticism. These researchers interpreted these findings, explaining that wives who perceive their husbands are unhappy with their weight, or who make regular, negative comments

about their wives' weight, are more likely to report low self-esteem, low body satisfaction, higher body criticism, and feelings of unattractiveness (Carels, et al., 2020). It can be concluded that people who perceive that their partners are not happy with their weight, or whose partners make negative comments about their weight, may feel less attractive and experience lower body satisfaction overall. This may help psychologists to understand why being in a relationship can help increase body satisfaction for plus size people, especially for those who believe their partners are attracted to them and whose partners do not make negative comments about their weight or body. The researchers concluded that wives in the study who reported frequent occurrences of husband criticism and negative comments reported the highest levels of weight bias internalization.

Fatphobia, Body Image, Relationship Satisfaction, and Sexual Health for Plus-Size Heterosexual Women. Razmus (2019) hypothesized that the relationship between body satisfaction and romantic relationship for plus-sized women was even more complex than it is for straight-sized women. Razmus created a study to compare body appreciation and body-pride in plus-size women and straight-sized women. A pool of 344, mostly married (68%) women living in Poland, ages 19 to 57 were surveyed. Using BMI as a measurement of size, about two-thirds of participants were straight-sized ($N = 215$), and about one-third were plus sized ($N = 129$). Measures that assessed body satisfaction, self-esteem, and affect were given to each participant. Straight sized individuals reported higher levels of body appreciation and body pride in comparison to plus size individuals in the sample. However, after taking relationship status into account, there were no significant differences in body appreciation and body pride between these two groups. These findings indicate that for single people, being plus sized is associated with negative body attitudes. Being in a romantic relationship may be a protective factor for plus sized

individuals, where they experience more body appreciation and body pride compared to single plus sized individuals, and significantly similar rates as straight-sized individuals. This is important because it indicates that there is some difference in the satisfaction of plus sized individuals with their bodies when they are single versus when they are in a relationship. It can be hypothesized that being in a relationship, and the subsequent support, words of affirmation, and feelings and safety, may serve to increase body satisfaction for plus size people (Razmus, 2019).

Lee and colleagues (2021) pulled data from a sample of participants from the Iowa Midlife Transition Project, specifically sampling heterosexual married couples who participated in the project in the years 1989, 1994 and again in 2001. This longitudinal study was conducted to determine if an association exists between marital hostility and body weight in middle-aged couples. Participants were asked to answer questions about their mental and physical symptoms, their body weight, and their partner's behavior. Three-hundred and seventy couples were included in the sample for a total of 740 participants. Participants were all White, heterosexual couples living in rural areas, were between the ages of 31 and 68, had a median annual income of $70,000.

Husbands in the Lee et al. (2021) sample were found to exhibit a greater number of hostile behaviors than wives in the study. About 35% of the couples reported that hostile behaviors occurred in the home half of the time or less. A univariate growth curve was estimated using an analytic model, and body weight was significantly correlated with increased levels of marital hostility for the couples in the sample. The researchers reported that participants who perceived their husband or wife as being consistently hostile had elevated psychological distress and higher body weight comparatively. This study indicates that martial hostility may increase

when a partner's weight changes significantly over time (Lee, et al., 2021). Partner weight was also associated with less relationship satisfaction and less body satisfaction. Thus, individuals who have a higher body weight may be at risk for experiencing hostile behaviors in their relationships and may experience less body satisfaction and relationship satisfaction than individuals who have a lower body weight.

Fatphobia, Body Image, Relationship Satisfaction, and Sexual Health for LGBTQ+ Women. LGBTQ+ women have multiple marginalized identities that foster unique life experiences (Kashubeck-West, et al., 2018). Unfortunately, there is limited research that exists on body image and relationship satisfaction for LGBTQ+ women, and even less for plus-sized or fat LGBTQ+ women. A review of the literature that does exist concludes that LGBTQ+ women, and particularly those who identify as plus-size or fat, may be at high risk for body dissatisfaction and relationship concerns due to experiences of fatphobia and marginalization (e.g., Chmielewski, 2010; Taylor, 2020). This dissertation seeks to explore this topic and generate more information about the nuanced experiences of plus-sized LGBTQ+ women.

Chmielewski (2010) conducted a qualitative study that explored LGBTQ+ women's experiences of their bodies. Chmielewski found that perceived attractiveness was a concern for most LGBTQ+ women, but particularly for bisexual women who were dating men at the time of the study. One participant expressed that she often avoided having sex with her male partner after eating because of bloat. Another participant expressed that she often avoided dating men because she felt that male partners had objectified, shamed, and judged her body in the past. These perspectives are in line with current feminist theories about the internalization of the male gaze (e.g., Monoro-Dominquez, 2019). Chmielewski (2010) also found that many lesbian participants in the study reported feeling less sexual or attractive because they did not fit into

societal standards of beauty of femininity. However, despite the sexual orientation of the participant, most women in the study reported a desire to change their body weight and shape. Despite a desire to change their bodies, most participants reported that they were actively trying to accept and love their bodies (Chmielewski, 2010).

Kashubeck-West and colleagues (2018) wanted to explore objectification, body satisfaction, physical intimacy, and relationship satisfaction in bisexual women. Two hundred and seventeen women participants, aged 18-57 and who were predominantly White and middle class, were surveyed. About two-thirds of the sample reported they were currently in a relationship with a man, and about one-third reported that they were currently in a relationship with a woman. Participants were given asked about body consciousness, eating disorder history, relationship satisfaction, body image, and demographic information. Bisexual women in this study reported high levels of body self-consciousness during sexual intimacy, and they also reported low levels of sexual satisfaction. No differences in partner gender were found. However, bisexual women in the sample who were in relationships with women partners reported higher levels of relationship satisfaction than did bisexual women currently dating men. These findings indicated that body self-consciousness impacted sexual intimacy for the bisexual women in this sample, but that body self-consciousness and sexual satisfaction were not associated with relationship satisfaction for these women. Kashubeck-West et al. (2018) concluded that the protective benefits of relationship satisfaction do not buffer the negative effects of body self-consciousness and body dissatisfaction on physical intimacy for bisexual women.

Narula and colleagues (2019) conducted a study to better understand the experience of relationship satisfaction and body image for transgender women. One hundred women, half

transgender (N = 50) and half cisgender (N = 50), participated in a research study of relationship satisfaction and body image. All participants completed questionnaires that assessed relationship satisfaction and body image. Transgender participants were recruited from the Nazariya LGBT Organization and cisgender participants were recruited from Delhi-NCR. Descriptive information about the participants (age, sexual orientation, race, ethnicity) were not reported. Independent samples T-tests were conducted, and relationship satisfaction for these two groups was not significantly different. Transgender participants in the study reported slightly lower levels of body satisfaction than cisgender participants, but these results were not significant. Narula and colleagues (2019) hypothesized that, based on these results, transgender people are not at greater risk of relationship dissatisfaction due to lower levels of body satisfaction in comparison to cisgender folks. It should be further clarified that this study did not assess the association between body image and relationship satisfaction for transgender or cisgender participants, though other researchers have established that a direct, negative relationship exists between body image and relationship satisfaction for most people (Lee, 2017).

Moreno-Domingues and colleagues (2019) wanted to compare the differences between body satisfaction in heterosexual and LGBTQ+ women. In a survey of 354 women who were bisexual, lesbian, and heterosexual, no significant differences in body satisfaction were observed (Moreno-Dominguez, et al., 2019). Participants were asked to complete surveys that assessed for body satisfaction and sexual satisfaction. An ANOVA was conducted to compare bisexual, lesbian, and heterosexual women's scores. For the women in this study, lesbian women reported the highest level of sexual satisfaction and the highest body satisfaction scores. For lesbian women in the study, there was no significant relationship between sexual satisfaction and body satisfaction. However, for bisexual and heterosexual women, a significant, direct relationship

existed between sexual satisfaction and body satisfaction, such that as body satisfaction increased, sexual satisfaction increased. Moreno-Dominguez and colleagues (2019) interpreted this as a result of perceived mate attractiveness, where bisexual and heterosexual women may experience their bodies as less attractive to potential male partners, and thus experience less sexual satisfaction. These researchers argued that this tendency to assume male partners will find their bodies unattractive is related to a feminist theory called internalized male gaze, which is a phenomenon where women internalize cisheteronormative beliefs about what men find attractive about women's bodies. Moreno-Domingues and colleagues (2019) concluded that lesbian women do not experience an internalized male gaze, and thus are more satisfied with their bodies.

Taylor (2020) utilized a thematic analysis approach to interview 10 queer, fat, femme women, and explore their experiences of dating using open ended questions. Taylor found that the majority of women in this sample expressed feelings of fetishization from men, and rejection from women. These women reported that their experiences made them feel undesirable, and these feelings of undesirableness lead them to fear dating or feel like a failure for unsuccessfully finding a partner. Taylor (2020) argued that queer, fat, femme women experience multiple levels of marginalization that put them at risk for relationship and body concerns.

Summary: Fatphobia's Impact on LGBTQ+ Women's Body Image, Relationship Satisfaction, and Sexual Health.

It is clear that women are susceptible to unrealistic and harmful messages about their bodies from society, and particularly from the media. Women internalize messages about what their bodies should look like, and what is considered attractive from various sources, including peer interaction, social comparison, and the media. Various types of societal messages and social

comparison perpetrate disordered eating behaviors, negative mental health impacts, and create issues within couple dynamics (Lee, et al. 2021; Ferguson, 2018). Women experience greater levels of body dissatisfaction compared to men, and they are less likely to accept and love their bodies when they perceive that their male partners do not like their bodies (Carels, et al., 2020). Plus size women were found to be more likely than straight sized women to experience body dissatisfaction when they are single. However, being in an accepting and affirming partnership can help to increase a plus size women's body satisfaction (Razmus, 2019). Lesbian, queer, and bisexual women who are dating other women may experience greater satisfaction with their bodies and with their relationships as compared to queer, bisexual, and heterosexual women who are dating men (Kashubeck-West, et al., 2018). This may be due to WLW (Women Loving Women) being outside of the male gaze, and women in relationships with men internalizing cisheteronormative societal standards of body image (Moreno-Dominguez, et al., 2009).

It is important to note that the majority of research on body satisfaction and fatphobia is from a White, Western lens. The majority of participants in these studies are White and cisgender. Such samples may have resulted in a slanted picture, given that women of color, and particularly Black women, have been reported to experience greater body satisfaction than White women (Winter, et al., 2019). Latinx women also report higher body satisfaction in some domains, including satisfaction or appreciation of their skin, as compared to White women (Winter, et al., 2019). More research on the nuance of women of color's experiences are vitally needed. It is a determinant to the health of women of color to exclude their experiences from these discussions. Specific sampling and pointed recruiting measures should be used in order to generate more diverse samples and thus showcase the experiences of women of color in these studies.

The use of BMI as an indicator of health has been criticized as racist and outdated (Springs, 2019). Many of these studies utilize BMI as a categorical descriptor of body sizes well as a way to measure the health of participants. This method of categorization, involving a formula based on just weight and height, is rooted in White supremacy because it was created by a White man with a sample of only White men, and it ignores the natural variability of body types represented in other populations. Furthermore, BMI is grounded in a health model of wellbeing that is outdated and logically fallible. BMI and health are not correlated and using these variables as synonymous for one another perpetuates fatphobia and stigmatizes fat individuals. Future research on body size and health should take into consideration a number of factors such as risk behavior, physical health diagnoses and symptoms, and experiences of oppression related to body size rather than BMI.

The Proposed Study

Experiences of fatphobic discrimination can be negatively impactful for fat LGBTQ+ women in a variety of ways, such as: (a) putting them at risk for mental health disorders, such as depression, anxiety, and eating disorders (e.g., Wu & Berry, 2017; Himmelstein et al., 2018); (b) increasing risk of physical health problems, such as high cortisol levels, high blood pressure, and diabetes (e.g., Friedman et al., 2017; Kinavey & Cool, 2019); and (c) contributing to social problems, such as dating concerns and lowered sexual and/or relationship satisfaction (e.g., Van den Brink, et al., 2018; Carels, et al., 2020). Fat LGBTQ+ women may report unique experiences of fatphobia as a result of: (a) their gender expression and adherence to masculinity and/or femininity, (b) their beliefs regarding gender roles, and (c) the gender and/or gender expression of the person they are in a relationship with. I plan to conduct a qualitative study using Corbin & Strauss' (2008, 2015) Grounded Theory methodology, involving interviews with fat LGBTQ+

women about their experiences of fatphobia. Particular focus will be on experiences of medical and relational fatphobia, and how these experiences have impacted these women's mental health, self-image, and romantic relationship quality.

This study will be created with the intention of working from an emic approach, gathering data from a specific subsection of a community (i.e., women who are both fat and queer). Purposive sampling methods will be utilized in order to create a rich and representative data set, with particular attention focused on recruiting women of color, women with disabilities, and women of a variety of ages, sexual orientations, and geographic locations. In qualitative research, there are not a priori hypotheses that are tested. Instead, qualitative researchers focus on the desired information that will be sought from the participants. Major research questions will include:

1. How do fat, queer women feel about their bodies?
2. How do societal messages impact how fat, queer women feel about their bodies?
3. What types of fatphobic experiences have fat, queer women faced?
4. How do societal messages impact fat, queer women's romantic relationship satisfaction?
5. How do experiences of fatphobia impact fat, queer women's romantic relationship satisfaction?

This study has potential benefits for participants, practitioners, and scholars. First and foremost, I hope that through participating in this study, the participants will feel that their experiences were affirmed and that they were not alone in their struggles with fatphobia. Furthermore, I hope to utilize this research to inform practitioners who work with fat, queer women and LGBTQ+ couples by providing insight into their lived experiences and to ensure

quality care is being provided to this population. I plan to use the data from this study to create a list of tangible suggestions of how to practice therapy in an affirming way with fat, queer women. I want to disseminate this work so that both mental health professionals and medical providers will have access to it, and thus be better informed about the negative impacts of fatphobia. My hope is that through this research and other fatphobia research being conducted within the field, the impacts of fatphobia will be taken seriously by both mental and physical health practitioners, and thus professionals within these fields will work to address and minimize fatphobic experiences that occur during healthcare visits.

CHAPTER 3

METHOD

Participants

Participant recruitment and data collection occurred using both theoretical and purposive sampling strategies (Corbin & Stauss, 2008; Palinkas, et al., 2015). Corbin and Strauss (2015) described theoretical sampling as recruiting a number of individuals in order to complete the task of conceptualizing themes that arise in participant experience, rather than to recruit a specific number of individuals. These researchers suggested that the goal of qualitative research recruitment is to achieve saturation, which is a point in data collection where concepts and themes are well-defined and fully explained. A researcher can feel confident to conclude data collection when all categories of the study provide a clear understanding of the topic. In order to ensure that a clear understanding of the phenomenon has been developed, each category must have enough depth and breadth, and relationships between the categories should be established (Corbin & Stauss, 2015). For the purpose of this study, a minimum number of 6 participants was recruited and saturation was reached at that time.

Palinkas and colleagues (2015) described purposive sampling as a strategy to recruit specific, data-rich cases that will aid in the understanding of the topic. This can occur by selecting participants who have relevant lived experience or who are especially knowledgeable about the topic. Purposive sampling is used to narrow down themes and find similarities within the sample, while still allowing for enough breadth to describe variation and differences of experiences within the sample (Palinkas, et al., 2015). For the purpose of this study, queer women were recruited in order to narrow down variance and find commonalities within the participants' experiences. However, intentional recruiting of queer women with various identity

differences, such as diverse sexual orientations, racial and ethnic backgrounds, and ability statuses would provide variations of experience.

It is common for qualitative studies to have smaller sample sizes than quantitative studies (Corbin & Strauss, 2008). This difference in recruitment is due to the difference in goals of the two types of research. Quantitative researchers want to recruit a large number of heterogeneous participants in order to establish out-group generalizability (e.g., generalizability to the global population), whereas qualitative researchers want to recruit a small number of homogeneous participants in order to establish within-group generalizability (e.g., generalizability to a specific group of people; Palinkas, et al., 2015). Date triangulation was achieved and data collection provided the framework to meet the goals of this study by using both theoretical and purposive sampling strategies (Denzin, 1978; Patton, 2002).

Approval for this study was obtained through Southern Illinois University Human Subjects Committee (HSC) prior to recruiting participants. This researcher purposefully sampled participants who identified as queer (i.e., bisexual, pansexual, lesbian, gay, queer, or non-labeled) women. The category of women in this study included all women who identify as cisgender, transgender, genderqueer, nonbinary, femme, feminine, and/or gender non-conforming women. Participants were at least 18 years old and self-reported that they were currently in a relationship with a woman (as defined above) at the time of the interview. Participants identified themselves using a label that indicates larger body size (e.g., plus-size, larger bodied, fat). This variation of sample body-description labels provided a range of ways in which people talk about and refer to their bodies. To reach saturation, I recruited 6 participants who consented to individual semi-structured interviews that took place via a secure video

conferencing platform (e.g., Zoom). Recruitment occurred via social media (e.g., Facebook, Instagram, Twitter, TikTok, Tumblr).

Materials

Qualitative research does not have formal measures for data collection (Levitt, 2021). Instead, qualitative researchers can use theoretical frameworks, such as Grounded Theory Method, to guide their recruitment and data collection processes. Taking into consideration the purpose of the project can help researchers determine which type of data collection method fits best for that specific project. For the purpose of this project, a semi-structured interview protocol was utilized to collect data. Semi-structured interviews are a very common data collection approach, because they allow for the research to be guided by the researchers' questions and objectives while still allowing the participants freedom to share what they wish in their own way.

Demographic and Screening Questionnaire

Participants were first be given a consent form (Appendix B). After the participant agreed to proceed with the study, a demographic questionnaire (Appendix A) was given with the intent of collecting identity information, such as participant age, race, ethnicity, nationality, sexual orientation, gender identity, education, income, and ability status. The demographic questionnaire included questions that asked the participant about their relationship and current partner. Participants were asked to disclose their current relationship status, and those that were currently single, widowed, or divorced were thanked for their participation and screened out of the study. Participants were also asked to disclose their conceptualization of their body size, and participants who do not describe themselves using the larger body-size language (e.g., plus-size, larger bodied, fat) were thanked for their participation and screened out of the study. Participants who were currently in a relationship and described themselves as larger-sized were asked

whether they consented to participate in a 30-60 minute semi-structured interview to discuss their experiences of fatphobia and relationship satisfaction. Participants who met all inclusion-criteria and consented to an interview were provided a survey link to provide contact information (e.g., email, phone number) and scheduled an interview. Participants who completed the semi-structured interview were provided with a $20 e-gift card as compensation for their time.

Semi-Structured Interview Protocol

A semi-structured interview protocol (Appendix C) was created to explore participants' experiences of fatphobia and how these experiences may impact their relationship satisfaction. Participants were asked various questions about experiences of oppression related to their body size, such as microaggressions or experiences of victimization that have occurred as a result of the person's body size. All participants were asked a standard set of core questions, such as: (a) feelings about their body, (b) experiences where someone made them feel bad about their body, (c) how societal messages about what bodies should look like impact their feelings about their body, and (d) how their relationship with their body impacts their relationship with their partner. See Appendix C for all core questions included in the semi-structured protocol. Participants were also asked about the quality of their relationship and their overall satisfaction with their relationship, including sexual satisfaction. Participants were then asked follow-up questions to facilitate additional conversation. For each question in the protocol, there were 3-5 example probes that were used to follow up a participant's answer and aid in the data collection process if need be. Some examples of possible probes used are included in the semi-structured interview protocol (Appendix C). Feedback from Dr. Jose Arroyo, a practicing psychologist and LGBTQ+ practitioner, and Shelly Ridgeway, a licensed professional counselor and plus-size practitioner, were solicited and incorporated in the creation of the protocol. Additionally, active listening and

relationship skills of the primary researcher were used to build rapport and facilitate productive interview conversations with the participants.

Procedure

Qualitative research allows for an exploration of people's lived experiences, feelings, thoughts, and beliefs. A strength of qualitative research is that it allows for the generation of rich data. However, a weakness of qualitative research is that the process can lack structure, and researchers can end up with a lot of data that is hard to make sense of. For this reason, Grounded Theory Method was utilized to give structure to the qualitative research process.

Grounded Theory Method

This study was conducted using Grounded Theory method (GTM), a qualitative research methodology based in the post-positivist paradigm (Corbin & Strauss, 2015). This paradigm suggests that objective truth and objective reality can only be approximated, which functions under the belief that reality is socially constructed. However, the post-positivist paradigm shares with positivism the desire for some kind of prediction and control, so theory building is one of the goals of this qualitative method. Grounded Theory has been widely used, and there are specific procedures in place to ensure that this methodology is accurately conducted (Corbin & Strauss, 2008). Concepts from the data were identified, and relationships between them explored, until a four core categories emerged that helped to organize the researcher's understanding of the data. These core categories, also referred to as the story line, allowed the researcher to make sense of the data and helped the researcher to build a theory that was grounded in the data. This form of qualitative methodology allowed for a rich understanding of the results, generated completely from participant's lived experiences (Creswell, 2013).

During Ground Theory analysis, the researcher played an active role as both a research tool and instrument of investigation (e.g., Glaser & Strauss, 1967; Guba & Lincoln, 1985; Morrow (2005) provided recommendations to researchers in order to prevent biases, assumptions, and expectations from skewing the research results. Some of these recommendations included fostering reflexivity, which included discussing and/or journaling about the researchers' lived experiences and identities that contribute to the data. Additional considerations for the researcher(s) included their current and previous experiences with the population of interest, their training and educational experiences, and any current bias, assumptions, or expectations being carried into the research process. These biases can influence the questions researchers choose to ask, the topics being studied, the participants recruited, themes identified, and understanding of the relationship among themes (e.g., Polkinghorne, 1984; Morrow, 2005). I am the investigator of this study, and I identify as a fat, queer woman who's lived experiences of fatphobia have directly and indirectly impacted past and present relationships. Whereas some researchers have argued that lived experience is a rich and vital form of knowledge, others argued that lived experiences can create biases and assumptions that may impact the researcher's objectivity (Alase, 2017; Morrow, 2005).

To combat these biases, Morrow (2005) suggested that researchers should overtly discuss their biases, assumptions, and expectations with others and come back to them throughout the research process. Using another researcher to externally audit the data is one way to help combat research bias (Creswell & Miller, 2000). For the purpose of this study, an undergraduate research assistant was utilized as an external auditor. An audit trail was maintained during the study, which included all research materials (e.g., researchers journal, notes and memos during the interviews and analysis, products at each stage of the analysis). The auditor assessed the concepts

and relationships articulated by the primary researcher and met with the primary researcher to discuss potential bias in coding. Furthermore, Osborne (1994) suggested that researchers should use a technique called *bracketing* to avoid bias, which in this study will consist of frequent, intentional meetings between myself and the auditor to aid in the self-reflection process throughout the course of the research project. For this reason, the researcher and auditor engaged in informal check-ins that discussed researcher bias and subjectivity. During this time, the auditor and primary researcher had journaled about their thoughts and feelings about the project in their research journals, as well as their biases or expectations, and brought them to the check-in to share and discuss with one another.

Data Collection

The primary researcher created a flier with a recruitment link that highlighted the purpose of the study and information about who met criteria to participate in the study. This flier was posted to their social media accounts, and the primary researcher invited people on social media to share their flier with their followers as well. The recruitment link took interested parties to a survey that allowed them read informed consent procedures and fill out demographic information. Those who met criteria to participate and had provided consent to participate were screened by myself, and I choose which participants to set up an interview date with. I purposefully interviewed participants with a variety of ability statuses, sexual orientations, ages, and socioeconomic backgrounds.

Individuals who were selected/invited consistent with purposive sampling, and who consented to participate, engage in a private, semi-structured interview with the researcher via Zoom. Interviews were recorded via zoom, and the interviews were be conducted using the semi-structured interview protocol. In order to make the process as simple as possible, consent to

audio and visual recording via zoom were included in the informed consent procedure and were required of all participants as an aspect of the inclusion criteria. As needed, follow up questions were asked using probes listed in the interview protocol (see Appendix C). Observations, thoughts, feelings, potential biases, and expectations of the researcher were recorded in a journal after each interview, as suggested by Corbin & Strauss (2008). The video recordings and journal entries were stored on a password encrypted flash drive in order to protect the privacy and confidentiality of the participants. The flash drive was kept in a locked filing cabinet as a secondary source of protection. Analysis of each data set was conducted after each interview, and the results of the data were used to guide later sampling via a theoretical sampling procedure (Corbin & Strauss, 2015).

Data Analysis

In order to prepare each interview for analysis, audio from the recordings, and visual cues such as body language, facial expressions, and emotional expressions from the videotape were documented and transcribed. After each interview, the transcription process occurred and thought units were identified. Thought units are segments of data that represent a single discreet thought, and they can vary in length from a single word to a paragraph or more. The process of breaking transcribed data into chunks is called unitizing (Levitt, 2021). In preparation for the analysis, the thought units were conceptualized, and notes about the meaning of each thought units was recorded. Three levels of analysis occurred using the GTM model: (a) open coding, (b) axial coding, and (c) selective coding (Corbin & Strauss, 2015).

Open Coding. During the open coding stage, thought units were compared with one another, identifying similarities and differences. Similar concepts were grouped together and thus a category was formed. Thought units that did not fit into a category formed the basis of

new categories or subcategories and were continuously compared to new thought units from newer data sets. This process was called the Constant Comparative Method (Glaser & Strauss, 1967). New thought units were compared to current categories and were either: (a) added to an existing category, (b) used to create a subcategory or evolve a current category, or (c) were used to create a new category. Thus, as the data analysis unfolded, categories evolved. Participant recruitment and interviews continued, including transcription, unitizing, conceptualizing, and open-coding, until the open-coding level categories reached saturation.

Axial Coding. After open coding concluded, axial coding began (Corbin & Strauss, 2015). During this stage, organization of the categories took place. Categories were organized into higher-order categories, where subcategories begin to emerge and a larger, overarching core categories arose. Based on themes that emerged, these open-coding level categories were placed into clusters which formed a hierarchy. Smaller or simpler categories were organized under these clusters so that they could supplement the higher-level clusters with nuanced detail. This detail allowed the clusters to be more clearly and accurately understood.

Selective Coding. Finally, higher-order clusters from the axial coding phase began to come together around a common theme or idea, known as a core category. A core category typically emerges from the axial-coding process, around which all of the other axial level and open coding level categories can be organized. A theory is created based on the core category that links all of the previous higher-order categories, and thus creates a cohesive story. The core category is sometimes referred to as the story line and is the basis for grounded theory. Levitt (2021) suggested that a good core category has fidelity, meaning that it both improves the reader's understanding of the phenomena and meets the goals of the research project.

I utilized Rennie's (2000; 2012) methodical hermeneutics approach to build my theory. This approach utilized (a) education, (b) abduction, (c) theorematic deduction, and (d) induction to build the theory. Education was the process that occurred first and involved using the researcher's lived experience and formal education to determine what was meaningful about a particular piece of data. Abduction was the next process that occurred, where a label was generated that effectively explained the data it represented. Next, theorematic deduction took place, determining what particular new thought unit or data source was examined next. Finally, induction occurred by finding commonalities between the thought units across the data to explain patterns. The grounded theory then represented the content and process of the participants and their experiences of the phenomena.

Ensuring the Quality of Qualitative Research

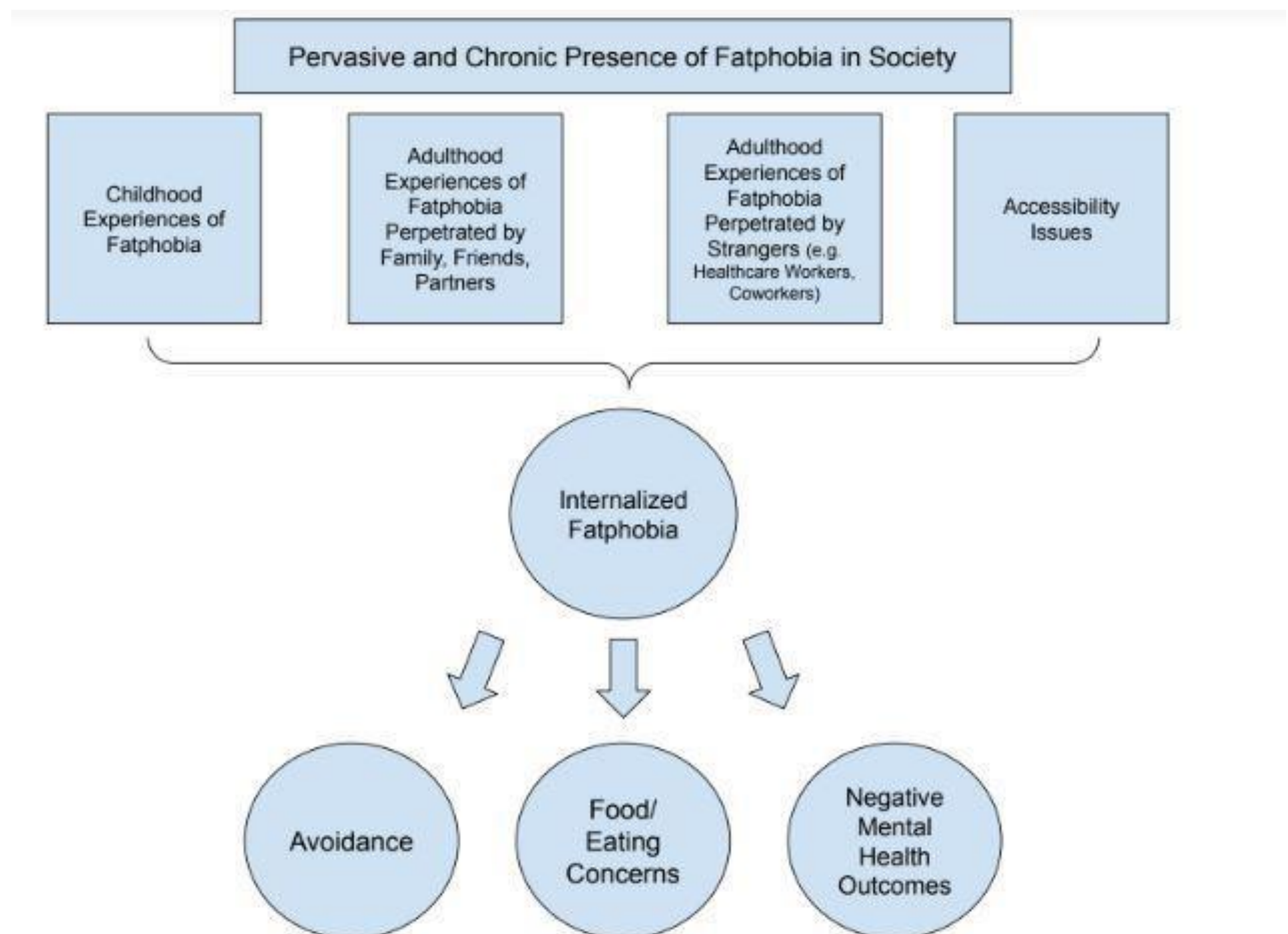
It is important to ensure methodological integrity when conducting qualitative research (Lincoln & Guba, 1985). Methodological integrity should guide researchers to select processes and design their procedures that strengthen their study and produce trustworthy results. Fidelity, which includes data adequacy and groundedness, ensures that the research project captures the phenomena intended. Data adequacy is a concept that entails recruiting participants for the purpose of showcasing differences in experience within the population being studies. For the purpose of this project, purposive sampling of ability status, age, gender, and socioeconomic status were prioritized. Racial and ethnic backgrounds of participants will be purposefully sampled for. Unfortunately it may not be possible to adequately recruit participants with a wide array of identity variables within the limited number of interview slots and limited project timeline.

Groundedness in qualitative research indicates that individual participant quotes should be included in the project write up in order to illustrate meaning. For this project, individual participant quotes were utilized in the write up of this dissertation to ensure groundedness. Utility, or making sure the research project methodology will meet the goals of the study, is another important aspect of qualitative research (Lincoln & Guba, 1985; Levitt, 2021). Contextualization and catalyst for insight are components of utility. Contextualization is a term that describes the usefulness of providing participant context, such as culture, to help readers interpret participant quotes (Levitt, 2021). In the write up of this study, participant contextual factors were discussed when quotes were presented. Additionally, catalyst for insight, or optimizing participant potential for insight, will be considered as well. Participants were interviewed over zoom, which allowed them to meet with me in the comfort of their own homes. I utilize interpersonal skills, such as warmth and active listening, to ensure that my participants felt comfortable talking with me. I also self-disclosed that I identify as a queer, fat woman in order to establish a working alliance during the interviews.

CHAPTER 4

RESULTS

The purpose of this study was to explore the concept of fatphobia in the lives of plus-size, queer women, with particular interest in identifying common experiences and determining overall impact of fatphobia in their lives. The results of the qualitative analysis of interviews of six, plus-size, queer women show commonality in experience of these women, but they also reveal the complexity in the impact of fatphobia in their lives. A model, grounded in these data, is presented below and in Figure 1.



In this study, there was one core category that emerged from the data, at the selective coding level of analysis, and served to capture these women's experiences of fatphobia. The overarching category that helps us to understand these women's experiences is the pervasive and chronic presence of fatphobic microaggressions. Four major axial coding level sub-categories emerged as well, which served to represent the impact of fatphobia for these women. The four sub-categories that represent the impact of fatphobia for these women are (a) avoidance, (b) accessibility concerns, (c) food/eating concerns, and (d) intentional body work. In this chapter, I will first illustrate the nature of these women's fatphobic experiences and then how they were affected by them.

These findings have clinical implications for healthcare providers, as they illustrate the ways in which fatphobia is negatively impactful on queer women's physical and mental health, well-being, and quality of life. However, it should be noted that many of these women expressed positive feelings about their bodies and reported intentional body positive work (i.e., purposefully changing the way that one thinks about or relates to their body, the way that it looks, and the things that it can do) that acted as a form of resilience (i.e., the capacity to cope with and adapt to chronic stressors). These categories do not represent linear impacts (i.e. sequential, direct consequences) of fatphobia, and they do not represent the experiences of all fat, queer women or all women in general. In order to truly understand fat, queer women's experiences of fatphobia, it is important to understand both the negative and the positive effects of fatphobia in their lives. This model will be discussed, first according to each type of fatphobic microaggression (i.e. childhood external, adult external, internalized), and then the effects or consequences of these microaggressions will be discussed (i.e. avoidance, accessibility, food/eating concerns, and intentional body work).

Pervasive and Chronic Presence of Fatphobic Microaggressions

All six participants mentioned pervasive and chronic experiences of fatphobic microaggressions, starting in childhood and continuing into adulthood. They highlighted specific experiences, such as being bullied in elementary or middle school by peers, having their bodies talked about negatively by their parents, being told to lose weight by family members or friends, and even having strangers make negative comments about their bodies or unsolicited suggestions about weight loss. These experiences were said to start in childhood, as early as could be remembered, and continued throughout the lifespan into adulthood. Most participants reported that such comments have become less overt as they age, and tend to be focused more on health concerns. In this category, participants suggested that these microaggressions are something that there is no reprieve from, as these microaggressions are perpetrated by doctors, teachers, children, parents, close relatives, friends, coworkers, and even strangers.

Childhood Experiences of Fatphobia

About two-thirds of these participants reported experiencing fatphobic microaggressions as early as elementary school. These women reported that they felt they had been bullied by childhood peers solely because of their body weight or shape. Bullying occurred throughout all aspects of school, but that physical education class (PE) was a primary space for bullying to occur.

> Because you do the presidential fitness test, so you're all standing in a line together. They as how tall are you? How much do you weigh? And the BMI charts right there. So anybody standing around you could go, Oh, so and so is five four. And she weighs this much. That means she's morbidly obese. So like, I'm sure the school thought they were

> just helping encourage all of us to look better and be healthier, but like, fuck off. I'm a child.

Experiences of parents or close family members making comments about children's bodies was another dimension that arose from the data. These women indicated that their mothers and fathers, grandparents, and siblings would make negative comments about their bodies, push them to lose weight, or dictate what they could or could not wear based on their body shape. Most participants reported that being bullied in childhood created negative self-esteem and caused them to internalize fatphobic beliefs about themselves and others.

> I went out to the car from my house wearing overalls with a white sports bra under them and then like a flannel shirt on top. And my dad was like, no, you can't wear that. I was like, this is what everyone wears, Dad, like, this is so cool. And he was just like, not you, your body can't do that.

Participants were also forced or encouraged by parents to lose weight by a variety of means. Calorie deficit, limiting certain food groups, increasing exercise, and using weight-loss medications were a few of the tactics participants mentioned their parents had used to induce weight-loss. Some family members shamed them for their food choices or the quantity of the food that they ate.

Adult Experiences of Fatphobia from Friends/Family

In adulthood, these women were still not safe from family- or friends-perpetrated fatphobic microaggressions. Such microaggressions included having a family member or friend suggest that they should diet or exercise more. All participants reported having been told at least once that a family member or friend was concerned for their health, which is why they were

encouraging them to lose weight. Some participants agreed with or sympathized with their family members' concern for their health, but the majority of participants did not.

> I feel that my mother wishes I was smaller because she wants me to be healthy. However, I don't believe weight and health are interchangeable terms. I, umm, I think my mom was indoctrinated into believing that I must be unhealthy because I'm fat, but actually I am perfectly healthy. (scoffs) My blood pressure is fine, my cholesterol is fine, I exercise often. I'm just fat. I, I think the health concern is a bullshit lie society has perpetrated because of like, the BMI, and racism, and like, unrealistic beliefs about women's bodies.

Adult Experiences of Fatphobia by Strangers

Another important idea to emerge from the data included adulthood experiences of fatphobia made by strangers or people they did not know well. The majority of participants described various experiences of fatphobic microaggressions by strangers. These experiences ranged from random incidents (e.g., "I was just running along my street and then a guy, it was always a guy, he like rolled his window down and was like, he tried to sell me like a weightloss milkshake cleanse.") to shaming by healthcare workers (e.g., "I remember my new doctor shamed me by pointing at a graph of my BMI which showed that my weight was way above average. I remember leaving the office crying and felt so ashamed and mad and sad."). Some fatphobic microaggressions perpetrated by strangers happened online, such as dating online or using social media (e.g., "The tinder one like started as a comment on how big my breasts were. And then it was like, but it ain't worth it. Or something like, tits are a 10 body is like a three.") These participants believed people felt they could make negative comments about their bodies easier or with less consequences online (e.g., "So anyway, people were coming at me [on TikTok], calling me fat and saying, you need to lose weight. Maybe you should hit up the gym.")

Internalized Experiences of Fatphobia

Many people who experience chronic microaggressions start to believe the negative things that people say about them. The process of believing the negative things that people say about you is called internalization. All participants reported experiences of internalized fatphobia. Some of these experiences included negative beliefs about themselves or their bodies, shame or guilt about being fat or gaining weight, and a desire to shrink one's body or lose weight. The following quote showcases the way in which women, and particularly fat women, are influenced by society to dislike or feel dissatisfied with their bodies. This dissatisfaction seems to lead to a feeling of pressure to conform with societal standards, and thus shrink oneself into a smaller, more acceptable size. This is an example of internalizing fatphobia, because the message being told to women is to dislike their bodies and to avoid being fat, and so fat women start to become dissatisfied with their bodies and begin to believe that they should be smaller or skinnier.

> I think the cultural messaging towards bodies is particular to women's experiences. I think being a woman, I certainly have been taught to be small, and that is not something my body will ever be. And so I have spent a lot of energy adjusting my personality and adjusting my relationships to kind of accommodate for the fact that my body is so big. I've spent some time trying to be a smaller energy or presence to balance that. I think being a woman I have also been taught to be dissatisfied with my body. like there's not a whole lot of space to be super happy about a person's body as a woman. I'm sure that is true to people of other genders, too. But my experience is that it's true for women. And so even at times my body in my life where there has been kind of a crossroads of, be happy or be unhappy with my body, I think that cultural messaging has really taught me that it is more appropriate to be unhappy with my body.

When asked where they believe they learned to feel ashamed of their bodies, almost all participants reported that they felt they learned to think negatively of themselves from their parents. Fat children listen to their parents' dissatisfaction with their bodies and desire to be smaller, and thus they learn that they too should feel that way about their own bodies (i.e. dissatisfied, desiring to be smaller). This process seems to align with psychological theories of observational learning, where children watch their caregivers and learn how to think or behave based on observing what their parents are saying or doing (e.g. Bandura's bobo doll study; Bandura et al., 1961).

> My mom was always a bigger person, too, until she got cancer. And I mean, my mom went through chemo twice, and the first time everybody brought like food to the house, because that's how you support somebody who can't cook. And mom ate everything. And she put on weight. And she was pissed, because she said she was fatter now than when she started chemo, chemo is supposed to make you lose weight. So, when the cancer came back and she had chemo again, she was so happy with herself, because she lost weight again.

Other participants reported that they learned to feel ashamed of their bodies because of the way that healthcare providers treated them. Since healthcare providers are considered experts on health and wellness, fat people might feel pressure to accept or believe their advice or commentary about their bodies/weight/BMI. This behavior seems to align with psychological theories on obedience and authority, such as Stanley Milgram's shock experiment where the majority of participants complied with commands given by someone in perceived authority (Milgram, 1974).

> I also have spent quite a bit of time doing fertility treatments and have been turned away from multiple clinics because of my size. Or have been like only welcome at the clinic if I go through a whole bunch of really gross anti-fat like lessons like, Oh, you need to

> meet with this person to talk about all the risks about being fat before you can proceed with our clinic.

Avoidance

Avoidance was a common strategy that many participants learned to utilize for minimizing experiences of fatphobia in their everyday lives. There were many spaces or activities that participants reported were particularly unsafe for fat people, and all of these women avoided these spaces or activities whenever possible. Some participants suggested that they avoided going to the doctor or seeking routine medical care because of experiences of fatphobia in the past.

> I remember when I first went to the general practitioner about like low mood and I, it was like I had issues like self-harm and stuff, but I would have been 12 or 13, and the GP told my mum that I probably really benefit from like getting out, doing some exercise.)

Fatphobia experiences also caused some of these women to avoid things that others would consider fun or exciting, like going to the public pool, eating out at a restaurant, or going to an amusement park (e.g. “I've avoided certain activities I love because I cannot fit into those spaces, such as going to an amusement park and riding a roller coaster or going to the beach in a bikini.”) Many participants also talked about avoiding health-producing behaviors, such as exercising or working out, in order to avoid being microaggressed, judged, or having people give unsolicited weight-loss advice (e.g. “If I like run on a treadmill at the gym it's loud because I have like heavy footsteps because I'm running a bunch of pounds and like, I don't like making that sound because I don't like people to turn and be like, oh my god or whatever.”). It seems like for many participants, avoidance is a coping strategy that has been learned over time. Avoidance

of activities might ensure that they are not micro-aggressed, judged, or shamed. However, this avoidance creates other problems in their lives, such as limiting fun activities that they are able to participate in and reducing the number of opportunities to engage in physical activity or receive healthcare services.

Avoidance of Healthcare

One of the biggest arguments that is typically made against the concept of body positivity is that body positivity glorifies obesity. Furthermore, individuals who make such arguments often equate weight with health (Cernik, 2018). One interesting theme that arose in these data was avoidance of healthcare as a repercussion of fatphobic experiences. This is important, because it suggests that fatphobia might actually increase the likelihood that fat folks won't seek healthcare, which could be a possible explanation of some health differences that have been reported between fat and thin people. Participants reported that they tended to avoid going to the doctor, because they feared being judged or shamed for their weight, or because they had had experiences in the past where doctors did not believe them or misdiagnosed them because of their weight.

> I was put on three different weight loss meds before I was 16. The first at six, second at 10, third at 14, which, nothing fucks with a child more than being told you're too fat and you're not doing enough by yourself, so we're going to put you on drugs. To force you to lose weight. And I can't help but think that that may be messed with my metabolism. Which kept me fat as an adult. Where maybe I might not have been as fat. Because if you're chemically adjusting the metabolism of a six year old, that's going to have long standing effects. I don't know how anybody thinks it wouldn't. Except that I'm fat, so it's justified to treat me poorly. And last Tuesday, I had a neurosurgeon try to recommend

> that I have gastric bypass because I was too fat and clearly I was lying about how much I was eating. And, you know, the fact that I was in there because I can't currently walk because of issues with my back, but he says he can't do back surgery until I lose weight, so he recommended me to have weight loss surgery. And how I'm too fat for one surgery, but not too fat for the other makes no sense.

Other participants talked about being misdiagnosed by their medical providers.

> So one time I had this like super bizarre thing at work where I just kind of went blind for like five minutes. I just couldn't see. I was totally freaked out. And I got a same day appointment with the doctor, with whichever doctor was available, not mine. And I walked in and I was just like, I don't know what's happening. And the doctor said, well, it's probably diabetes. I was like, I'm not diabetic. She was like, well, we should check, you're probably diabetic. That was so clear, she looked at my body and made assumptions about what was happening based on just how I look. She'd never met me. It wouldn't say anything like that in my chart.

Fat women learn to avoid going to the doctor, because they will be shamed for their body weight or size, or offered unsolicited solutions for losing weight, such as fasting, taking dieting pills, or having weight loss surgery. These solutions, while maybe considered helpful from a doctor's perspective, perpetuate the idea that there is something inherently wrong or unhealthy about being fat and that their bodies need to change. For some fat women, this might be connected with internalized feelings of shame or dissatisfaction with their bodies, where they might interpret these doctors' comments as having failed at being healthy or failed at being the correct weight. Other times, fat women's health concerns are not taken seriously by doctors or are misdiagnosed. It seems that doctors often see their patient's weight as the cause of all underlying root health

concerns, rather than considering that weight could be a consequence of an underlying health condition (e.g. hypothyroidism) or unrelated to their particular health concern altogether (e.g. birth defect). When fat patients are consistently misdiagnosed by their physicians, it seems to create a tendency for patients to avoid going to the doctor because they start to lose trust in doctors' ability to accurately treat them.

Another disturbing health risk associated with fatphobia was being denied or delayed treatment by their medical provider. A doctor would not deny a smoker life-saving lung cancer treatment, nor would they deny someone surgery for correcting collision related injuries associated with drunk driving. However, doctors can and will deny fat people life-saving treatments. Doctors are not immune to societal influence, and thus doctors may have been educated to believe that fatness is a moral failing that is associated with a lack of will power or a lack of discipline. Thus, these doctors might believe that increased will power and discipline will help their patient lose weight and will fix the medical issue. Again, this belief is rooted in the argument that being overweight makes someone inherently unhealthy, and thus losing weight will create better health.

> It took me five years to get properly diagnosed with my knees. They believed it would just be relieved if I just exercised more. They gave me some bullshit diagnosis and the cure for it was working out. So they'd send me to physical therapy, and I did physical therapy three times over five years because they believed that if I just strengthened the muscles around my knee all would be well… So it like it took so long to get a diagnosis because they kept saying, you just need to work out..

Avoidance of Gym/Exercise

Exercise is another health- behavior that participants reported avoiding. Exercise is directly correlated with decreased risk of cardiovascular disease, diabetes, and some cancers, is shown to improve chronic conditions like arthritis and chronic pain and has been associated with a longer lifespan (CDC, 2022). However, all six of these women routinely avoid exercise or going to the gym in order to prevent being microaggressed due to their body size or weight.

> But walking in and you, every gym I've been to, you walk in and there's just that row of treadmills. And inevitably, there is a plethora of girls who look like they were the kind of girls who would have picked on me in high school, whether they are or aren't.

It's important to note that the majority of these participants reported being concerned about anticipated fatphobia at the gym, rather than having actually experienced fatphobia in the gym. It seems that the majority of participants had not experienced fatphobia-based microaggressions while at the gym, but instead anticipated judgement or fear of microaggressions was enough to keep them from going to the gym. This seems to connect to internalized fatphobic beliefs, where fat women might anticipate judgement at the gym because they themselves feel that they don't belong there or don't deserve to take up space in the gym. This tendency to avoid could also be a learned reaction to avoid places that are considered unsafe, where a space such as a gym is societally considered a place where people go to try to stay in shape, get healthy, or lose weight and thus could be considered unsafe to a fat person who believes that others view their body as inherently unhealthy.

A few participants reported having a hard time finding a place that they could exercise where others wouldn't see them (e.g., "The place I felt safest going to just walk around was a cemetery. Because dead people don't judge you, and nobody's going to say it to you if you're

walking around a cemetery because you might be sad.") One participant reported avoiding exercise entirely, because even after having decided to exercise outside instead of at a gym, they were still microaggressed by a stranger on their jog.

Avoidance of Food/Eating

All participants avoided eating in public to some degree. Strategies included behaviors such as avoiding eating in public or avoiding ordering more food than their friends at a restaurant.

> But I remember we got ice cream one time and I told him, like, I have to finish mine first, like you better not finish yours first. Because if we're walking down the street and I'm having, if I have ice cream and you don't, like the way that people will experience that is terrifying. Because they're going to have all sorts of knowledge and information about my body and my lack of willpower or my like slovenliness or something, if I don't have ice cream and you don't. But the other way, if you have ice cream and I don't, they'll think what a good job I'm doing by not indulging in something so ridiculous.

Disordered eating behaviors, such as severely restricting their food intake or hiding the food that they eat from family or friends, were also occasionally used by these women. It seems that fat women have learned that people in their lives may judge them for what or how much they eat, so they begin to learn to hide what they are eating from others, avoid eating foods that are considered unhealthy, or limit how much food they eat to comply with societal eating standards. A behavior such as hiding the food that you eat can be considered a coping response (e.g. avoidance of microaggressions, shame, judgement) or a shame-based response (e.g. not wanting others to know what you are eating because you feel shame that you are eating). For most fat women, it seems that the tendency to hide food, restrict food, or avoid eating certain foods is

both a coping response and a shame-based response. Hiding food is a symptom often seen in individuals with Binge Eating Disorder (BED), and restricting food or avoiding food are symptoms seen in individuals with Anorexia-Nervosa, Bulimia-Nervosa, and Binge-Eating Disorders (American Psychiatric Association, 2013). Fat women may be at an increased risk for developing an eating disorder if they engage in these behaviors (National Eating Disorder Collaboration, 2017). Societal judgement of fat people for what they eat or how much they eat could be increasing the likelihood that fat people develop eating disorders.

> So, after work, I'd work like three to eleven. So after work, I usually like get fast food on my way home. And I mentioned something to him about getting McDonald's. And he's like, you know, you're over here trying to lose weight, but then you're going to McDonald's every day after work, and then you're getting upset that you're gaining weight. So, I mean, I guess I started... You know, I tried to stop eating fast food at that point. Or like, if I did, I kind of, like hid it or didn't tell him, you know, so maybe I'd be on the phone with him and be like, Oh, I have to get off the phone, and then I'd stop at McDonald's or whatever. I stopped telling him, because I knew he would say something.

Avoidance of Dating and/or Sex

Some participants reported that they felt they had had significantly fewer dating or relationship experiences than their peers because of their body weight or size. These women avoided putting themselves out there, dating above their perceive league, or matching with certain people on online dating apps for fear of being rejected or made fun of. A few participants reported having been emotionally abused in relationships, because their partners were fatphobic (e.g., "He straight up told me to my face that I was too fat and ugly to fuck while looking at me, so he had to do me from behind.") A common reported behavior was creating online dating

profiles that make their body weight and size known. It seems that many fat women feel that they owe those who are viewing their profile the truth about their bodies. It is important to note that LGBTQ+ women who date men reported the tendency to post full body pictures on their online profiles whereas LGBTQ+ women who solely date women did not report this. This interesting finding indicates that fat women who date men may be at a greater risk of being microaggressed online when dating, or they may feel less safe dating online based on anticipated responses to their bodies. Nonetheless, the tendency to feel that showing your entire body on your dating profile is important may be another tie to internalized fatphobia, where these women may anticipate that future partners might dislike their body weight, shape, or size because they personally feel dissatisfied with themselves. However, it is important not to dismiss the real lived experiences of these women, many of whom reported cruel comments from partners about their weight from strangers online.

> I always put full body pictures on my profile to weed out assholes who would comment on my body. I'd also avoid swiping on people who looked like they were "out of my league" or who I felt might not be attracted to me because of my size based on my own assumptions, like people who were super fit or had pictures in the gym.(Gracie)

A majority of participants felt their sex lives with their current partners had been impacted by their own internalized fatphobia, which made them less likely to want to engage in sex or made them more self-conscious during sex. It seems that internalized dissatisfaction with one's body might be impacting these women's willingness to engage in sex and/or the ability to enjoy sex while engaging in it. A few participants mentioned feeling unsure what to do with their body or how their body looks during sex, which seems to be related to concern about how their partner may feel about their body. This fear about what their partners think about their body is

again is tied to anticipated rejection, which turns into the tendency to avoid sex altogether or engage in sex less often. Engaging in sex less often may create additional barriers to future sex engagement, such as making these women feel less connected to their partners, or making sex more painful, and thus less may create the tendency for these women to be less likely to want to engage in sex in the future.

> My own discomfort with my body for so many years made it hard for me to, like, enjoy different kinds of sex or feeling open to talking about sex or what I wanted or needed. Yeah, my inability to like, be in my body comfortably. Definitely made sex less fun for a long time.

Another participant reported feeling that their body isn't sexy or attractive (e.g., "Mostly my weight has impacted my sex-life because of my own insecurities, like I didn't feel sexy or hot, so not wanting to be seen as fat so turning the light off, or avoiding certain positions or trying new things or avoiding sex altogether.") Some participants reported feeling worried that their partners weren't attracted to them because of their bodies. If fat women feel uncomfortable in their bodies during sex, because they worry about what they look like, this might make sex less pleasurable for them and make them less likely to want to engage in sex. Some avoidance behaviors, such as turning the lights off or being unwilling to have sex in certain positions may create unfavorable experiences for their partners, which could create the tendency for their partners to be less likely to want to engage in sex in the future as well. Their partner's lowered libido could then be interpreted by these women as a result of their partners not being attracted to them, but instead might be a result of their own avoidance behaviors during sex. Avoidance behaviors during sex thus have the tendency to create a negative cycle in fat women's relationships and could impact relationship satisfaction for couples in which feel that sex is important to them.

Accessibility

Accessibility (i.e. the ease of ability to use, enter, or obtain something) was a common concern for all participants. Participants reported that they felt their lives as fat people were much different than the lives of people who are not fat because of barriers they faced to access or use certain spaces, treatments, or needs. For instance, participants had experienced life-threatening barriers, such as lack of access to healthcare or medical treatments. Other barriers that limit the ability for fat people to have fulfilling and satisfying lives, such as the ability to sit in an airplane seat, ride a roller coaster, or shop for clothing, also impacted them. Fat people expressed that they experienced barriers that made their lives much harder than the lives of straight-size people, because even simple tasks like buying a new outfit for attending a funeral, eating a meal at a restaurant, or going on vacation could be complex, difficult, or impossible. Being unable to do things that straight-size people can do impacted these women's self-esteem and quality of life. It seemed that these women would internalize experiences involving lack of accessibility as a moral failing of their bodies. Many of these women reported that they would feel shame, humiliation, and embarrassment if their bodies prevented them from accessing a space, such as not being able to fit into a booth or not being able to find a prom dress that fit. Stoll (2019) argued that a lack of accessibility is a result of a capitalist society that cares more about profit than people, not a moral failing. However, it seems that many fat people internalize a lack of accessibility as a personal failure, which creates negative feelings, such as shame and body dissatisfaction (e.g., “I can't even go into Kohl's necessarily and look around for clothes, because what if somebody there sees how big I am and realizes that they don't have clothes for me?”)

Accessibility in Healthcare

Fat, queer women report having trouble accessing healthcare services. As stated earlier, doctors routinely deny fat people surgery or treatment because of their body weight. Some doctors will require patients to lose weight before they can have surgery. Sometimes doctors deny fat people surgery because patients must be under a certain BMI in order to undergo anesthesia, since the U.S. healthcare system relies on a racist, outdated standard of practice such as the BMI (Strings, 2019). Other times, doctors will deny a fat patient surgery and require them to lose weight, because that doctor believes the reason for their surgery is related to their being overweight. It may be true that some fat people's need for surgery is weight related, but this is not always true; Would it be okay for a doctor to deny a smoker with lung-problems a lung transplant until they stop smoking for a certain period off time? Another common experience of many fat women is misdiagnosis from healthcare providers. When we stop to consider this hypocrisy in the healthcare system, it is apparent that fatphobia creates an unfair bias that creates a lack of accessibility for affirming healthcare for fat people.

> When I finally got the referral to mental health because I lied about having symptoms of an eating disorder. I'd been to my general practitioner about suicidal thoughts maybe four or five times. And I'd had like issues with like self-injury from like maybe 11. And by that point I was like 15. But they didn't believe me until I told them I had stopped eating and I was fat. And I've always thought that if I wasn't a fat person, I don't think that would have been my experience at all.

One specific experience of fat queer women who date women is the possible need for reproductive care that can include fertility treatments such as invitro fertilization. Invitro fertilization is a common route for reproduction for WLW couples. Unfortunately, in order to be

eligible to receive invitro fertilization in most clinics, women must have a BMI of 19 to 30 (National Institute of Clinical Evidence, 2010). According to the Center of Disease Control (2018) the average women's BMI in the United States is 29.1. At this time, there is no evidence that women with BMIs higher than 30 are at an increased risk of death or serious injury, nor is their baby more at risk, if invitro fertilization is preformed (Satha, 2010; Banker, et al., 2017).

Access to IVF came of as an important health care access issue in this study. Many fat women have a hard time finding clinics who will provide them invitro fertilization treatments (Sole-Smith, 2019). However, fat, queer women are at an even greater risk of not being able to find clinics who will treat them, because many fertility clinics cannot accept health insurance for fertility treatment from same-sex couples due to legal definitions of fertility that insurances use to determine coverage (Stein, 2022). Fat, queer women are made to jump through hoops to access fertility treatments, or are unable to access them altogether, meaning that they may not be able to have children unless they lose weight. It's important to note that some people have medical conditions that make it extremely difficult or impossible for them to lose weight- thus, because of medical fatphobia, some fat women may not be able have their own children.

> Because to get IVF you have to have a BMI of under... It's something ridiculous. It's just something absolute ridiculous. We like, we had a conversation that what we really wanted to be able to qualify for IVF. We decided maybe we should try and lose weight, but not weigh ourselves. Just like try and lose weight so that one of us would be able to potentially be able to do that by like the legitimate means. Because there's no,,,there are no clinics that take fat people. (Maddie)

Accessibility of Seating

Fat women often have a hard time finding spaces that are safe and accessible for fat bodies. Most participants expressed frustration at lack of inclusive seating for fat people on airplanes, in restaurants, on roller coasters, and at events (e.g., "I feel like I can't even go to a restaurant with family or friends without googling pictures of the place to see if I can fit in their tables or booths. You know, it just makes my life so unnecessarily difficult because people won't buy chairs that fit us."). Lack of accessible seating creates the tendency for fat women to avoid enjoyable activities such as traveling or going out to eat with friends, because either they know they won't be able to fit in the seat or they fear being embarrassed or ashamed if they find they are unable to. This lack of accessibility is something that impacts fat women's quality of life, as they are limited to what they can do and where they can go, or they require diligent research up front to determine where they can go. Many fat women reported feeling frustrated that they have to consider what spaces they can fit into, and often have to stay home or say no to participating in activities, whereas straight sized people don't have to. It seems that these concerns are a part of many fat women's mental load, and is cognitively taxing. Lack of accessible seating also creates a tendency for fat women to lack the opportunities to socialize, and may impact their ability to keep and maintain, go on dates, or play with their children. This may impact fat women's self-esteem, or cause negative mental health symptoms, such as anxiety and depression. People who are overweight are at an increased risk of experiencing anxiety and depression than those who are not overweight (Sarwer & Polonsky, 2016).

Accessibility of Clothing

Grabbing a quick outfit at Kohls or Target before a wedding or funeral may seem like an easy task for most people, but such a basic thing may be a stressful and difficult experience for a

plus-size woman. Fat women in this study reported that many clothing stores do not carry their size in store, or those that do only carry clothing that are not in-style or are extremely expensive. While access to cute or inexpensive clothing may seem unnoteworthy, this is just another example of how fat women's lives are made harder by lack of access. Multiple participants reported humiliating and stressful experiences shopping for prom dresses and wedding dresses, which should be experiences that are fun and memorable rather than traumatic.

> Certain stores don't carry plus size clothing so shopping for a prom dress or homecoming dress in high school always made me cry and feel terrible about myself. Going shopping with friends at the mall was a nightmare, because nothing fit so I'd just pretend to shop and help them pick things out. (Abigail)

Food and Eating Concerns

The majority of these and other fat women report that they have tried dieting many times throughout their lives, the majority having started dieting during middle school (e.g., "I have tried just about every diet imaginable, including paying thousands of dollars for Nutrisystem meals, trying to eat less than 1,000 calories per day, trying running when I hate running, etc."). According to a study conducted by the National Library of Medicine, roughly 64% of five year old girls have thought about dieting (Abramovitz & Birch, 2000). Culture in the United States prioritizes and glorifies dieting; this is showcased in movies, magazines, television, song lyrics, and more.

Dieting

Dieting is not considered a disordered eating behavior in the DSM-5, although chronic and severe dieting practices are considered unhealthy by the National Institute of Disordered Eating (NIDE). According to the NIDE (2022), dieting is one of the most common forms of

disordered eating and a risk factor for most eating disorders. Dieting can include a wide range of behaviors including skipping meals, counting calories or macronutrients, eliminating food groups from your diet, severely limiting the amount or type of food that you eat, skipping meals, and fasting for hours to days at a time. Recently, research has been conducted to provide evidence that diets do not actually work for long-term weight loss (Mann, 2018). So, if diets don't work for long-term weight loss, why do people diet? Diet culture is a strong and powerful force in our society, and a desire to avoid weight gain and to lose weight is not easily unlearned. Fatphobia (i.e. a fear of, dislike of, or discomfort with fatness) impacts people's tendency to diet to avoid becoming fat. For fat people, doctors, friends, family members, and even strangers suggest dieting from early ages. Fat people are bombarded with messages that they should be dieting by television ads, magazines, etc. and family, friends, and even healthcare workers only perpetuate and reinforce that belief. Therefore, it is unsurprising to find that the majority of fat people have tried numerous diets over the course of their lifespans, often beginning at young ages (i.e. "I definitely like started Weight Watchers in middle school with my dad.")

Many fat women in this study reported restrictive and unhealthy attempts at dieting, including fasting for days at a time or starving themselves to lose weight (e.g., “Sometimes in high school before a dance recital I would umm go two or three days without like, eating anything to try to lose weight and look skinnier on stage.”). For the purpose of this study, respondents who had been diagnosed with an eating disorder were excluded from the study in order to gain a better picture about typical eating and feeding behavior for fat, queer women. Despite none of the participants in this study having been diagnosed with an eating disorder, all participants reported behaviors that could be classified as disordered eating behaviors.

Negative Relationship with Food

All participants in this study reported that they had a negative relationship with food, which was described by each participant in a unique way. Experiencing guilt or shame when eating higher calorie foods was a common experience for most women in this study, as was the tendency to binge-eat and engage in emotional eating. Most women in this study reported having been shamed or made to feel guilty about eating or food choices by family, friends, and even strangers, so it makes sense that these women would internalize these feelings of shame and guilt (e.g.,. "And I know, like I've had former family members say like, Oh, she's getting a second helping of her salad, does she really need that? It's like, I'm a vegetarian at Thanksgiving, yes, I need the extra salad.")

> And also the other thing that I really noticed is that I don't like, I don't like to cook. We have been people who order takeaways, because we don't like to cook. And I know I feel a lot of like for me, getting a takeaway like, that's a very, very shameful thing. Like, it's a really bad thing. And like, even though I know consciously at the end of the day, food is food, but like, it's just that that immediate like voice in your head that tells you, like, this is wrong.

The tendency to feel shame or guilt when eating higher calorie food reflected a category which was labeled *self-policing,* a type of trauma response where oppressed individuals will start to hold rigid expectations for themselves in-line with what is societally expected of them. Many participants reported a tendency to obsess over how many calories are in foods, or the type of macronutrients that a food is primarily composed of, such as carbohydrates, proteins, or fats. Self-policing may occur if a woman chose to eat a food that she deemed bad, such as a food high in calories, fat, or carbohydrates. If a woman eats a cookie, for instance, that is high in calories

and carbohydrates, she may begin to talk negatively to herself or about herself, inducing feelings of guilt and shame, which may lead to behaviors such as severely limiting calories or carbohydrates for the rest of the day or the following week (e.g., I will sometimes like, eat foods that are bad for me, like McDonalds fries, and feel so like, guilty, that I won't eat for the rest of the day or I'll like only eat carrots for dinner.") Participants reported eliminating entire macronutrient groups such as carbohydrates from their diets, or severely limiting the amount of calories that they eat per day. It is important to note that the amount of calories, protein, fat, carbohydrates, or other macronutrients in food does not determine if a food is healthy or unhealthy. From a Health at Every Size (HAES) perspective, food can be classified as more nutritious or less nutritious, but practitioners should avoid using words like healthy or unhealthy or good or bad to categorize food. It is also possible that these women have learned the behavior of associating foods with labels like good and bad, which creates feelings of shame or guilt when eating foods categorized as bad.

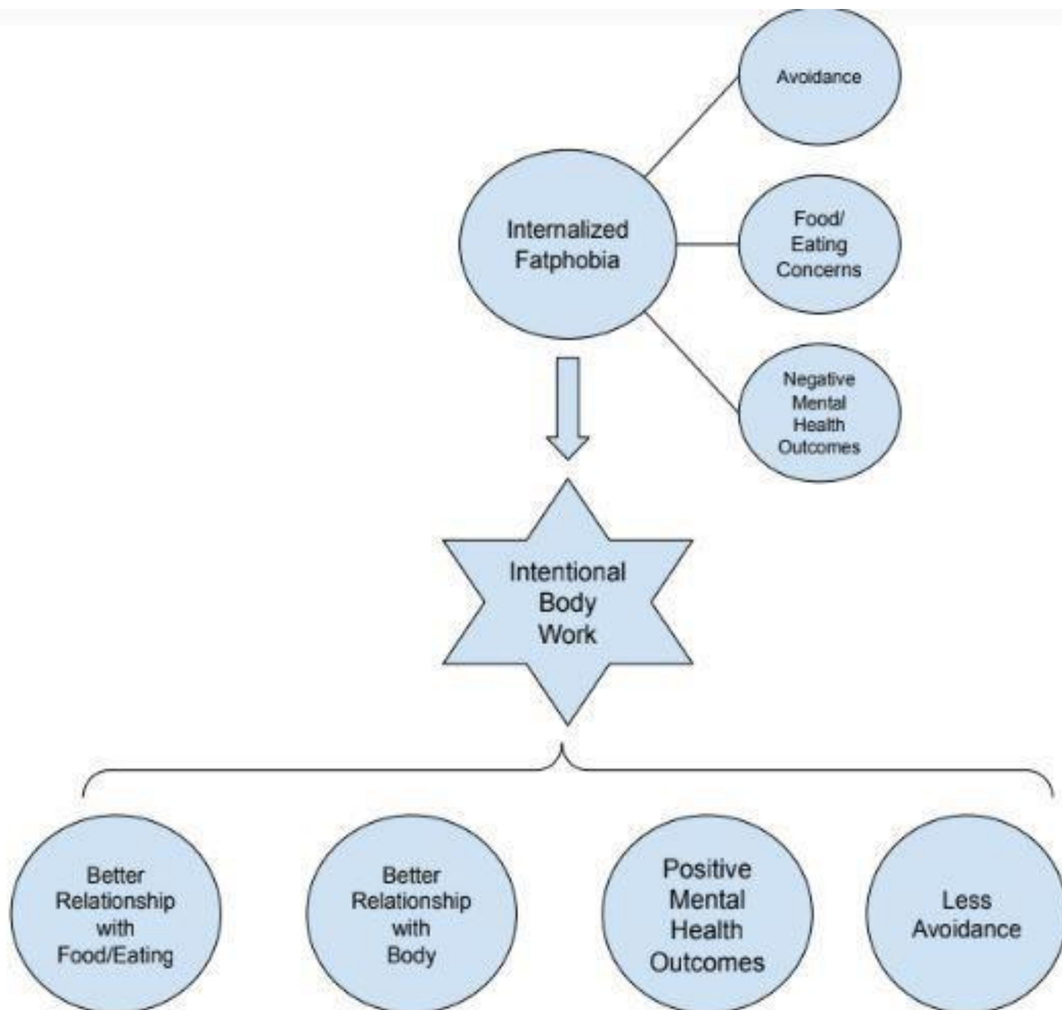
Emotional eating seems to be a coping skill for self-policing for some women, where eating more food is used as a way to mask the negative emotions that come with self-policing (i.e., shame, guilt, sadness). If a fat person eats a food that they consider unhealthy, self-policing processes may lead to feelings of shame or guilt, and they end up eating more of that food or other foods that they deem unhealthy in order to try to cope with those negative feelings and make themselves feel better.

Intentional Body Work

Intentional body work can be defined as purposefully changing the way that one thinks about or relates to their body, the way that it looks, and the things that it can do. A universal experience of the women in this study was their willingness to, and commitment to, doing work

to change how they feel about or relate to their bodies. This work can be a considered a form of resilience, a form of coping, a form of self-care, or, as was the case for many women in this study, an act of rebellion. A figure below (see Figure 2) emerged from this analysis that provides a visual representation of the ways in which internalized fatphobia is related to intentional body work, and the positive outcomes of intentional body work for fat, queer women.

Figure 2.



Body Work as an Act of Rebellion

These women powerfully described their intentional body work as an act of rebellion, in which they worked hard to learn to love their bodies and accept their bodies despite living in a society that tells them they should feel ashamed of and dislike their bodies (e. g., " Now I feel like it's an act of rebellion to love our bodies. Especially when they don't fit society's expectations.") Fat women who have faced years of oppression now have to do the hard work of unlearning and relearning how to love and appreciate their bodies. Not all of the fat women in this study reported that they were engaging in body work, but those who did reported that their self-esteem and mental health were much better because of it.

> It is really hard work to say, “I love my body, and I am thankful for what it does for me,” especially in a society that tells me that my body is, you know, wrong or bad or something. But ever since I like, changed my mindset and the way that I feel about my body, I like, feel so much better about myself and tend to be a lot less hard on my body and happier overall.

It seems that for women who chose to engage in body work, despite how difficult it may be to begin this process, their mental health and overall relationship with their bodies improve drastically. Participants reported that as they began to change their perspectives about their bodies, their relationship with food and eating, as well as their romantic relationships and friendships, improved as well (e.g. “When I decided to love my body instead of hate my body, my wife and I began to have sex more and I felt more comfortable cuddling or like, being touched by her in general.”)

Unlearning hateful, oppressive rhetoric about fat bodies was a common experience for these women. It is important to consider the term intentional, because this work is not being

asked of them or forced upon them. Instead, this body work is something that these women have sought out and fought hard to enact through rigorous processes that can include therapy, trauma processing, setting boundaries, learning coping skills, unlearning societal beliefs/expectations, and more.

> I think that is in the process of changing. I have spent most of my life feeling a lot of hatred toward my body. Sadness, grief, regret, disgust. A huge amount of my life has been really wrapped up in feeling dissatisfied about what my body looks like and just how my body is. I think in the last few years, I have spent a lot of time working on gratitude toward my body. Occasionally, excitement. I feel some pride about some of the things my body can do.

Queerness as a Resource for Body Work

An impactful finding from this study was that queer women overwhelmingly reported that their queerness helped them to find happiness and contentedness with their bodies. The queer community, in contrast to the LGBTQ+ community as a whole, seems to provide a safe space for conversations about body positivity and fatphobia.

> I think being queer has given me... I feel more, I think I'm more comfortable being a queer fat person and being in the queer community, because I think people in the queer community are at least on the forefront of things being more tolerant. And there's definitely massive elements of fatphobia in the queer community, I'm not denying that all. But I think if I go into like a queer space and say, like oh I'm fat, the response is is very different, because it's, I think, it's something that's discussed more, maybe because of like counterculture and stuff like that. So, I think that's helped me feel more comfortable kind of in my fat body.

Participants identified a difference between the queer community and the LGBTQ+ community, where the LGBTQ+ community has a history of fatphobia and excluding people of size, as compared to the queer community that engages with and is familiar with fat liberation (e.g., "there is a distinction I've noticed between the gay community in terms of fat liberation, fat acceptance and the queer community. I think there's a massive difference in that.")

Body Appreciation

Some women reported a distinction between being satisfied with or happy with her body and being accepting of or feeling neutral about her body. Body positivity and body neutrality are separate and distinct concepts, where body positivity promotes love and satisfaction of fat bodies, body neutrality focuses on releasing negative feelings about your body and regarding your body in a more neutral, appreciative way rather than a loving way. Body neutrality is often the first step to moving towards body positivity.

> I want to say I love my body all the time, but the truth is that I don't. Most of the time I feel neutral about my body, and I've worked hard to get there. I have days where I don't like parts of my body. This is typically triggered by seeing a picture or video of myself. I have certain parts of my body I feel less comfortable with, like my stomach hang or my arm fat or my boobs. I do have parts of my body that I like, and I generally believe that I am beautiful. I also try to practice body thankfulness, being thankful for what my body does for me and what my body can do.

For some women, it may be hard to go from hating, disliking, or loathing their body to feeling excited or loving towards their body. In this study, an intermediate process emerged that involved moving from a mindset of liking or disliking your body into a mindset of appreciation or thankfulness for what your body can do as a first step. A majority of the women in this study

reported that they feel that their body is strong and capable, and such beliefs have gotten them through a lot (e.g., " I feel some pride about some of the things my body can do.").

A figure (see Figure 1) emerged from this analysis that provides a visual representation of the ways in which fatphobia, in its many forms, is pervasive and influential in the lives of these fat, queer women. Diagramming is a common data display technique in qualitative data analysis (e.g., Verdinelli & Scagnoli, 2013). Fatphobia seems to impact both the external life of these women (e.g., where they can go, what they can do, how people interact with them) and also their internal lives as well (e.g., self-esteem, relationship with their bodies, relationship with food). Fatphobia shares characteristics with other forms of discrimination, in that it is pervasive, often occurs across the lifespan, and can come from trusted individuals (e.g., doctors, teachers) as well as strangers. Fatphobia is a unique form of discrimination, however, because it is often perpetrated by people closest to them, such as their parents, siblings, cousins, and friends, as well as trusted adults, such as doctors and teachers. It is hard to escape a form of discrimination that starts in childhood and occurs regularly in your own home. Unfortunately, the consequences of fatphobic discrimination effect the lives of fat, queer women by impacting their physical, mental, and relational health and well-being, and overall effects their quality of life.

CHAPTER 5

DISCUSSION

For decades, medical research has been championing a connection between weight or fat and negative health outcomes. In the last few years, a few select medical researchers have recognized that negative health outcomes associated with weight may actually be a consequence of weight stigma rather than weight or fat itself (e.g., Wu & Berry, 2018). Despite this recent recognition in medical literature that weight stigma may be an important factor in negative health outcomes for fat folks, many doctors and healthcare workers refuse to acknowledge the truth behind this research. Only in the last few years has attention been paid to the mental health impacts of weight stigma or fatphobia, meaning there are still few resources available on this topic. Even less is known about the impact of fatphobia on those in the queer community, and especially for women and femmes. The use of qualitative methods has been particularly useful in the field of psychology to gain information about the experiences of specific populations of people (e.g., Levitt, 2021). Thus, the purpose of this study was to conduct a qualitative examination of fat, queer women's experiences of fatphobia, with the goal to address gaps in psychological literature where current literature focuses primarily on medical fatphobia rather than mental, physical, and relational impacts of fatphobia. The primary purposes of this study were to: (a) understand more about queer women's experiences of fatphobia and (b) explore ways in which fatphobia impacts these women's' mental, physical, and relational health and well-being. Grounded theory methodology was used to develop an understanding of the phenomena of fatphobia for fat, queer women and femmes. This analysis provided a framework (see Figures 1 and 2) for the specific phenomena related to fatphobia and how they are related to one another.

Major Findings

An important outcome of this study was a broader, more nuanced understanding of fatphobia, particularly in the context of fat, queer women's lives. The conclusions of this study showcased that fatphobia is pervasive and chronic in the lives of these women. The majority of the women in this study reported that they considered themselves to be fat or overweight children, and that fatphobic remarks and experiences began as early as they could remember. Thus, for these women, fatphobia is an experience that they have been accustomed to their entire lives, and it is ingrained in their experience of the world.

Fatphobia is Chronic and Pervasive

As early as these women can remember, family members, friends, strangers, and even doctors have been making negative comments about their bodies, their size, their weight, their shape, their food choices, and their clothing choices. All these women know they live in a world that dislikes and feels uncomfortable with their bodies. These women reported that often their first memories of being told that their body is too big was from their mother or father. For these women, the person who was supposed to love them unconditionally told them from an incredibly young age that their body was wrong. Negative comments did not begin and end in the home, however. For the majority of these women, doctors also made it known that they were overweight or that their bodies were too fat. Many women in this study reported that they remember feeling ashamed, sad, or angry when visiting the doctor as a child because of how the doctor discussed their weight or their body. Many women also reported childhood friends, playground bullies, family members, and even strangers making negative comments about their bodies or their weight. These experiences are similar to the lived experience of many disabled people, who frequently report experiencing childhood bullying by family members and peers

(Pinquart, 2017; Fang, et al., 2022). Disabled people report a variety of ways in which they cope with bullying, but many studies indicate that people with disabilities often learn to avoid certain spaces or activities and utilize community to cope (Dali, 2018).

Unfortunately, experiences of fatphobia did not end for these women in childhood. Fatphobic remarks have been made by family, friends, doctors, and strangers throughout adolescence and into adulthood as well. Many of these women reported embarrassing or shameful experiences related to dating in adolescence, experiencing fatphobic remarks or comments from potential mates or partners via in person or online dating. Other women reported experiencing physical or emotional abuse relating to their body weight or size by their partners in early adulthood. In most married relationships, small acts of emotional maltreatment are considered common (Carney & Barner, 2012). In this study, a few married participants reported that their partners would occasionally make fatphobic remarks or comments, even if not directed toward them, that hurt their feelings or made them feel uncomfortable.

Internalized Fatphobia

It is not surprising then that the majority of these women learned to believe that their bodies were wrong or bad, which is evidence that they had internalized fatphobic beliefs. These women reported feeling ashamed of and embarrassed of their bodies, and they felt that their bodies were somehow wrong. According to a recent study conducted by Fallon and colleagues (2014), about 30% of women in their sample reported being dissatisfied with their bodies, and fat women were at an even greater risk of dissatisfaction. The majority of the women in this study reported wishing that they could shrink themselves or make themselves smaller, and out of this desire came avoidance behaviors and a negative relationship with food. A desire for thinness has

been shown to be associated with food restriction or avoidance (Izquierdo, et al., 2018).

Accessibility

These women reported avoiding activities such as going to the beach, going swimming, going to amusement parks, or flying because of both concern for how others might judge them if they were not able to engage with these activities, or because these activities did not allow someone of their body size or weight. Many women reported they have been unable to travel because they do not fit on an airplane seat, or that they aren't able to go to amusement parks because roller coasters are not accessible for someone of their body size. These women reported the tendency to look up seating at restaurants before arriving, to call and request a table instead of a booth to ensure that they would fit, to look up roller coaster or plane seat dimensions, purchasing two airplane seats, and more. For those women who might be able to engage in some of these activities, they are required to be diligent and complete stressful research to determine where and when they might be able to fit or to participate. People with physical disabilities, like those who use wheelchairs, report that they too have to complete difficult tasks such as scouting buildings with wheelchair ramps or calling ahead to determine if seating will be available (Cordts, et al., 2021).

Lack of clothing options, both online and in-store, also make regular every-day activities like shopping more difficult for fat women. The majority of these women reported that shopping is another activity that they often avoid. Many stores do not carry extended sizing or only carry these sizes online, which makes special occasion shopping like wedding dress or prom dress shopping frustrating and disappointing (Bishop, et al., 2018).

This world is not accessible for many people, including people of size. Lack of accessibility for disabled people is associated with negative physical and mental health outcomes

(Tough, et al., 2017). Fat women's quality of life and ability to engage in enjoyable activities are severely limited because of fatphobia. It is important that we recognize a lack of accessibility for all people, including people of size, and fight to create safe, welcoming, and inclusive spaces (e.g., Tough, et al., 2017).

Psychological Consequences of Fatphobia

Behavioral, emotional, and psychological phenomena emerged based on a lifetime of fatphobic experiences. It seems that the chronic presence of fatphobia in the lives of these women created behavioral tendencies, psychological health consequences, and eating concerns.

Avoidance

It is no surprise that women who experience chronic fatphobia, who grow up in a world that is not accessible to them, learn to dislike, feel uncomfortable with, or feel resentful of their bodies. Most of these women reported times where they strongly disliked their bodies or had negative self-esteem because of their body shape or size. These women reported that their feelings about their bodies impacted their mental health, specifically reporting depressive symptoms and social avoidance. The majority of these women reported the tendency to avoid social situations that required public eating such as eating at restaurants, eating during school, eating at work, or eating with friends or family members in social situations. This is an important contribution to the literature because eating and food are a large part of cultural traditions and social engagement for many people, and in many cultures, and thus fat people may be limiting their own abilities to engage with cultural traditions as social beings (Anderson, 2014).

This study shed light on the psychological consequences of fatphobia, including women's tendency to avoid pleasurable activities. The majority of these women reported the tendency to avoid dating or to avoid dating people that they deemed more attractive than them, possibly

because of internalized beliefs that fatness is unattractive. For those women in relationships, avoidance of sex was a common experience. Many of these women reported that they felt uncomfortable allowing their partner to see them naked or to touch parts of their bodies that they disliked, which could be a consequence of internalized fatphobia playing out in the lives of these women (Meiller, 2021). These women also reported avoidance of certain sexual acts or engaging in sex in certain positions that might emphasize their bodies or their weight. These women reported that sex was often a difficult part of their romantic relationships that they equated with negative self-esteem and discomfort with their own bodies. This contribution to the literature could provide sex and couples therapists vital information about the sexual relationships of fat, queer women.

An unfortunate health consequence of experiencing chronic fatphobia is that many women in this study reported that they began to experience avoidance of health-inducing activities. Some of these women reported avoiding exercising, going to the gym, receiving regular health check-ups, and going to the doctor for health concerns. Many women reported that exercising or going to the gym was off limits because of concern for being judged by others while exercising or feeling as though the gym was not a safe space for them. Other women reported having been harassed while working out by strangers and thus avoided working out altogether. Avoiding health inducing behaviors such as exercising or going to the doctor have been found to have negative mental and physical health consequences (i.e. Sulku, et al., 2020).

Most of these women reported experiences where their doctors had been dismissive of their health concerns, misdiagnosed them, or prolonged treatment due to their size or weight. All of these women reported a tendency to avoid going to the doctor or having negative experiences

with doctors/healthcare workers that made them less likely to go to the doctor when experiencing sickness, pain, or other health concerns.

Emotional Sequelae

The majority of the women in this study reported that they struggled with depressive symptoms, anxiety symptoms, and general self-esteem concerns. Other forms of internalized oppression, such as internalized racism, internalized homophobia, and internalized transphobia are correlated with negative emotional well-being (Mouzon & McLean, 2016; Newcomb & Mustanski, 2010). It is not surprising then that these women who reported experiences suggesting internalized fatphobia would also report negative psychological symptomology, such as low mood, a tendency to avoid pleasurable activities or socialization, increased or decreased appetite, and an increase in anxious thoughts. General symptoms of low self-esteem such as excess criticalness of oneself, making negative jokes about oneself, ignoring one's achievements or positive attributes, believing that one is undeserving or undesirable, feeling worthless, and comparing oneself to others were symptoms commonly reported by these women. Other researchers have found that fat women are more likely than thin women to report low self-esteem (Annis, et al., 2004).

The majority of these women also reported a negative relationship with food, so much so that many of these women reported symptoms that overlapped significantly with current DSM-5 symptoms of eating disorders such as Anorexia Nervosa and Binge-Eating Disorder. (American Psychiatric Association, 2013) Many of these women report negative relationships with food that include feelings of shame, embarrassment, and/or guilt when eating certain foods. These women reported having friends, family members, and strangers having commented on the foods that they ate and/or the quantity of food that they ate, which most likely led to the formation of these

shame-based feelings in relation to food. Most of these women explained that their relationships with food became unhealthy form a young age, most reporting beginning their first diet in middle school or early adolescence as a result of being bullied about their weight by peers. These women reported trying a plethora of diets, including extreme calorie deficit, intermittent fasting, prolong periods of starvation, and cutting out entire food groups or macronutrients. Living in a capitalist society in the United States, marketing companies thrive on convincing women that they should change their bodies or lose weight (Featherstone, 1982). Some social psychologists have linked a higher prevalence of eating disorders in women to weight-loss marketing and advertisement in the United States (e.g., Hesse-Bieber, et al., 2006). Many of these women reported spending thousands of dollars on fat diets over the course of their lives, most of which they had seen on television ads.

Some women reported that their doctors suggested these diets and/or prescribed weightloss pills. Unfortunately, research has shown that diets do not work for long-term weight-loss (e.g., Bacon, 2008; USDA, 2006; Bombak, 2017). Additionally, diets can be extremely dangerous for people with eating disorders or disordered eating behaviors (e.g., Neumark-Sztainer, et al., 2011). It is probable that women whose doctors tell them that they need to lose weight might begin to internalize beliefs that their bodies are bad or that they are failing at having a thin body. These beliefs might drive shame-based eating behaviors or avoidant eating behaviors, as evidenced by self-report of the women in this study (Oron, 2020).

Intentional Body Work

The majority of women in this study reported that they intentionally choose to engage in body work, which is a concept that emerged from these interviews. It is important to note that women who have spent less time unlearning fatphobic beliefs and who report higher levels of

internalized fatphobia may be less likely to engage in intentional body work and thus may be more likely to engage in avoidance behavior based on these data. *Body work* involves purposefully changing the way that one thinks about or relates to one's body, the way that it looks, and the things that it can do. Intentional body work involves engaging in behaviors such as attending therapy, changing their social media habits to include a more size-inclusive feed, reading books written by and for fat people, befriending fat people who are further along in their body work journeys, engaging with fat positive community, and more. The women in this study reported that society expects them to dislike their bodies, and thus choosing to relate to their bodies in a positive way is an act of rebellion and a key aspect of intentional body work. These women reported that they have shifted their focus to appreciating what their bodies can do or have done for them and what they like about their bodies rather than dwelling on the things that their bodies can't do or what they don't like about their bodies. It is important to consider that a first step to engaging in intentional body work may be to work on unlearning fatphobic beliefs, which is work that could be supported by a mental health professional.

Many of these women reported that intentionally choosing to change their relationships with their bodies has resulted in higher self-esteem, a better sex life, less avoidance, and a tendency to advocate for themselves in unsafe spaces, such as at the doctor's office. These women also report a likelihood to engage in behaviors that increase their quality of life, such as going out to eat with friends or going to the beach. Women who reported engaging in intentional body work also reported that their relationships with food improved, where they felt less inclined to engage in dieting behaviors and thus experienced less binge eating or emotional eating behaviors. These women also mentioned they felt less guilt and shame relating to certain foods, and multiple participants reported that they engaged with HAES eating principles or intuitive

eating practices (e.g., Bombak, 2014; Robinson, Bacon, & O'Reilly, 1993). Many of these women also reported that once they felt less unhappy with their bodies, they felt more inclined to engage in exercise because they were not exercising to lose weight but instead were focusing on using movement for a purpose (i.e. to improve mental health, to increase flexibility, to decrease back pain, etc.).

An Act of Rebellion

It is important to recognize that intentional body work is considered an act of rebellion for fat queer women. Many of the women in this study reported feeling that accepting and loving their bodies in a society that teaches them that their bodies are not desirable is a rebellious act. These women report feeling that they are fighting against the grain, against the status quo, to learn to love, desire, and appreciate their bodies. This act of rebellion seems to be linked to feelings of pride and empowerment for the women in this study. Empowerment is considered a primary outcome measure in psychology health research, because it is considered a tool for coping and overcoming trauma (Johnson, et al., 2008). Thus, using intentional body work as an act of rebellion may be an empowering and overall health-positive behavior for fat women that could help them navigate stressors related to fatphobia in their lives. .

Coping

Some fat women may use intentional body work as a way to cope with stress and trauma related to chronic fatphobia. For centuries, marginalized groups have utilized unique coping skills to manage trauma and chronic stress related to oppression (e.g., Silver, et al., 2021). Religion, community, food, and traditional rituals are some examples of coping skills that marginalized groups have utilized (e.g., Burstow, 2003; Fitzgerald, et al., 2021). Communities of color, and more specifically Black and indigenous communities, have spoken out about the

benefits of community-based coping for race-based trauma (e.g., Schultz, 2016). It seems that the fat women in this study have learned to utilize intentional body work as a way to cope with fatphobic stressors. A process of unlearning harmful beliefs and stereotypes and relearning loving, kind, and affirming beliefs seems to act as a way to process trauma and mediate stress for these women. Many of the women in this study suggested that following other fat women on social media and cultivating friend groups with fat women or body-positive women has helped them in the process of engaging in intentional body work.

Resilience and Strength

It is also important to recognize that intentional body work is a very hard, lifelong process that requires diligence, strength, and bravery. Many of these women reported that it is frustrating that they have to engage in this work when straight sized people do not have to. These women also reported that it is easy to slip back into negative thinking about their bodies, and thus they must continue to choose to engage in and with this work to continue to reap the benefits. Despite how difficult this work is, the women who reported that they engaged in intentional body work reported that this work is important, necessary, and worth it.

It is important to consider, though, that these women continue to engage in intentional body work despite the fact that it is hard. Many women in this study reported that this work is worth it because it allows them to love themselves more and fully engage or show up in their lives. The women in this study reported that this work allowed them better relationships with food, more pleasurable sexual experiences with partners, and a greater sense of self-love. It also seems that this work allowed the women in this study the ability to show up in their lives by pushing back on their tendency to avoid doing things that might be embarrassing, such as going out to eat with friends or going to the beach.

Fatphobia and Gender

All of the women in this study reported that they believed their relationships with their bodies were impacted by their gender. These women reported that they believed women in our society are expected to look and act a certain way, and many of these women reported feeling that their bodies were not able to meet these expectations because of its size, shape, or weight. These women reported that society expects women to look a certain way, citing attributes like curvy with a small waist, having a large butt and breasts, having a flat stomach, and having toned arms and legs (e.g., Levine, 2000). Many of these women reported feeling that because their bodies did not meet societal expectations, they felt like less of a woman or not feminine enough. This finding is similar to research conducted with lesbian women who reported that gender and body image were interrelated, where femininity and thinness are considered to go hand in hand (Kelly, 2006).

Fatphobia and Sexuality

Unfortunately, it seems that most of the queer women in this study were not an exception to negative feelings toward their bodies, despite research that suggests that queer women are sometimes able to reject societal gender norms (e.g., Ludwig & Brownell, 1999; Meyer et al., 2001). Fat, queer women in this study reported some specific ways in which fatphobia impacts them. A few women reported that they experienced difficulty finding doctors that would help them start a family via invitro fertilization. Many fertility clinics utilize BMI as an indicator of health and therefore exclude people of size from being able to access this specific medical care (Sathya, et al., 2010). Fat, queer women reported having to go to three or more clinics in order to find a provider who will even consider invitro fertilization as a method of achieving pregnancy. Fat, queer women may thus be unable to access medical services for child-bearing that allow

them to carry their own biological children, and instead are forced to rely on surrogacy or adoption as other means to becoming parents (Sole-Smith, 2019). Thus, fatness may actually exclude queer women from being able to become pregnant with and carry their own biological child.

Other fat, queer women reported experiencing fatphobia even in LGBTQ spaces. Gay bars, LGBTQ dating apps, and pride festivals were cited sources of microaggressions. Many of these women who experienced fatphobia in queer spaces reported frustration and disappointment that spaces that were made to be inclusive of one aspect of their identities (sexuality/gender) were still unsafe because of another sect of their identities (weight/body size) (Carter & Baliko, 2016). The duality of these women's experiences mean that they have less spaces to access safe and affirming community than straight sized queer people.

Despite negative experiences of being fat and queer, participants in this study also reported positive experiences of being fat and queer. Participants reported that they felt being queer allowed them to feel more comfortable with living outside of traditional norms of femininity in comparison to heterosexual women. Participants who were currently in a relationship with another woman, regardless of their sexual orientation, reported that they felt happier with their bodies than participants who were currently in a relationship with a man. Queerness could thus be considered a correlating factor contributing positively to overall wellbeing for these women. These findings support previous research that women in relationships with women often self-report that they are happier with their bodies than women in relationships with men (e.g., Yean, et al., 2013).

Implications and Applications

The conclusions of this study have many implications for fat women, allies of fat women, healthcare workers, therapists, and researchers. The stories that these women have shared can provide tangible ways in which healthcare workers, therapists, and allies can engage with and provide safe spaces for fat women in the future. These findings also point to ways in which people can cope with and address the adverse effects of fatphobia in their own lives. Results of this study can also be utilized to suggest future research pathways that may further engage with and provide clarification about fatphobia in a variety of communities.

Implications for Fat Women

To fat women reading this study: You are not alone. Your experiences are valid. Your hurt, your pain, your shame are noticed and are worthy of attention. Please know that other women, including this researcher who is a fat, queer woman herself, can understand and relate to the things you have experienced. Many of the women in this study suggested that by sharing their stories it provided them with feelings of clarity, strength, and hope. This would be considered evidence of this study's catalytic validity (Stiles, 1993), in that participating in the research process was beneficial to the participants.

Implications for Allies or Parents of Fat Women and Children

It is important to remember that the way people engage with others is impactful and important. Fat women, and fat children, need love, care, and support just as they are. All of these participants talked about the fatphobic messages they experienced starting at an early age from many important people in their lives, often under the guise of care for their health. There is no medical evidence that proves that fat women and children cannot be healthy (e.g., Rinaldi, et al., 2016). Additionally, there is no evidence that suggests shame or guilt improves peoples'

likelihood of becoming healthier (e.g., Pause, 2014). It seems, however, that the opposite is true—fatphobia decreases fat women's likelihood of accessing health-inducing behaviors such as exercising or seeking medical services.

If one has a child who is overweight, they should be taken to a fat positive clinician who uses a Health At Every Size (HAES) protocol to ensure that their doctor is committed to size inclusivity in health and is trained to avoid fatphobic rhetoric and behavior (Hanson, et al., 2020). A list of HAES clinicians can be found using ASDAH.org. More specific examples of ways that parents can support their children who are overweight include: learning to trust children to eat what is right for them and their bodies by encouraging them to listen to their bodies' hunger and satiety cues, engaging in healthy eating and exercising practices themselves and thus modeling this behavior for their children, educating children about food nutrients via intuitive eating practices that avoid labeling food as 'good' or 'bad', and avoiding negatively self-talk about one's own body or weight in-front of children (Crum, 2019).

Based on the results of this study, it might also be important to teach and engage in intentional body work for yourself and with children. For instance, a parent may be able to teach their child to engage with their body from the perspective of what it can do rather than what it looks like. A parent may also be able to teach their child ways to critically think about advertisements related to body image and food. For instance, parents may want to be aware of the people that their children follow on social media like Instagram or TikTok to ensure that they are not being taught fatphobic messaging about their bodies. It could also be helpful to ensure that your children follow fat content creators and celebrities to help normalize various body sizes and types. Lastly, parents may want to model intentional body work by avoiding talking negatively about one's own body or making shame-based comments about food.

According to the results of this study, it might be helpful for the friends, family, and allies of fat women to help them to find activities and spaces that are safe for them. It may be helpful as a fat-positive ally to call ahead to make sure there is seating that will accommodate larger bodies at a work event or family gathering. Small gestures such as planning shopping trips to include stores that carry plus-size clothing, or avoiding diet talk, can create spaces that are safer for fat people. It is important that fat allies do their own work to engage with fat positive literature and unlearn fatphobic beliefs that they may have learned growing up.

Implications for Healthcare Workers

Fatphobia is rampant within the healthcare system. There is little research that suggests that dieting works long-term (e.g., USDA, 2006). There is no cause and effect research that proves that fat people cannot be healthy, and instead correlational research suggests fatness is often related directly to poverty and genetics (e.g., Rinaldi, et al., 2016). There are major health implications for suggesting dieting, prescribing diet pills, or suggesting or providing weight-loss surgery, because these behaviors can create a tendency for fat people to struggle with low self-esteem, increased negative psychological symptoms, or disordered eating (e.g., Berg, 1999). It is important for healthcare workers to adopt and practice a HAES protocol in their work, by creating protocols that are safe for fat patients, such as seating that is accessible, options to deny weighing, equipment that fit all body types, etc. (e.g., Bombak, 2014). It is important for healthcare workers to be open to the idea that their biases regarding fatphobia could be impacting their willingness to treat or influencing their diagnosis (e.g., Harper, 2021). Fat patients deserve excellent, affirming, and safe healthcare.

Implications for Mental Health Professionals

Similar to other experiences of discrimination, fatphobia is pervasive and chronic (Boujaoude, 2010). Long-term experiences of discrimination can have devastating mental health impacts, such as depression, anxiety, and a higher likelihood of mood disorders, trauma related disorders, or eating disorders (e.g., Monroe, 2017). It is important to practice from a HAES protocol and do personal work to unlearn fatphobic biases that one may hold as a practitioner in order to avoid accidentally harming or misdiagnosing a client, as well as to aid in providing affirming care (Abel, 2020). Additionally, your office should be a safe space for fat patients, including accessible seating and equipment. It is important to consider how one's own biases could impact diagnoses or treatment plans. Considering the findings of this study, it may be impactful to suggest intentional body work as a coping skill for fat patients. Therapists may be able to help lead fat clients through steps to increase positive feelings regarding their body, unlearning negative rhetoric about their body, increasing their empowerment and likelihood to advocate for themselves, and more. A few specific examples of intentional body work that clinicians may be able to utilize with their patients include focusing on what their bodies can do or have done rather than what they cannot, dissecting and unlearning internalized fatphobia, cultivating self-compassion, focus on function vs. appearance, teaching mindfulness based interventions, and empowering women to confront experiences of fatphobia in their lives.

Implications for Future Research

Future researchers should focus on recruiting more diverse groups of women regarding race and ethnicity. Cultural differences may create significant differences in the experiences of women from difficult cultural or racial backgrounds. It could be hypothesized that Black women may have very specific experiences of fatphobia that are different than those who are not Black

due to the racial origins of fatphobia. In the future, researchers may want to recruit a larger number of participants in order to solicit a more generalizable sample. For the purpose of this study, a sample size of six was reasonable, but in the future a larger sample will be collected if a replication study is completed.

Given the results of this study, there are some implications for future research that may be considered. It is important to consider exploring the impacts of fatphobia in other populations. It is likely that men, trans individuals, nonbinary individuals, and gender expansive individuals may have very different experiences regarding fatphobia due to their gender identities. It is also possible that straight women may experience fatphobia differently, so a follow up study engaging with straight, fat women may help to determine if there are any major differences between findings. It also may be important to design a follow up study that compares women who were not fat in childhood to women who were, to see if their childhood or adult experiences are different. Based on the findings of this study, it seems that the experiences of women who were fat as children may be vastly different compared to those who were not.

Strengths and Limitations

A major strength of this study was the use of qualitative methods to provide an in-depth analysis of the experiences of fat, queer women. This study addresses a gap in psychological literature relating to fatphobia, specifically fat, queer women's experiences of fatphobia, and helps to expand our understanding of the phenomena of fatphobia and how it relates to mental health. This study also illuminates the chronic, pervasive nature of fatphobia as a type of discrimination that severely impacts fat people. Working to identify types of discrimination and helping to alleviate the impacts of discrimination is a goal of the discipline of counseling psychology and a tenant of psychology as a field.

Another strength of this study was that purposive sampling strategies were utilized to recruit women with a wide variety of sexual orientations and ability statuses, which helped to ensure a wide variety of viewpoints were accounted for (Patton, 1990). Participants in this study were interviewed via zoom, which was a strength because this allowed participants from a large geographic area to participate. Despite a relatively small sample size, this study also worked via an idiographic approach, which seeks to engage with one homogenous population rather than focusing on a monolithic approach which denotes generalizability in a large, diverse sample (Eap, et al., 2010). This research approach was created based on the field of psychology's history of cultural bias, where cultural variations in behavior and experience have been defined as deviance from the norm group and used to determine definitions of psychopathology. This monolithic approach has created cultural distrust in our field and has been utilized to encourage culturally insensitive treatment approaches against marginalized groups of people (Eap, et al., 2010). Thus, in this study, an idiographic approach was used where a small group of fat, queer, women were recruited and their experiences were studied in depth. Due to limited recruitment time and specific inclusion criteria, only White women were a part of this particular data set, though this researcher hopes to focus on recruiting a sample that focuses on fat, queer, women of color's experiences in the future.

One limitation of this study was its small sample size, as discussed above, which limits overall generalizability to the general population of queer fat women. Additionally, because of the COVID-19 pandemic, participants were interviewed via Zoom which seemed to create a barrier for participation for some people who did not have access to a quiet space in their home or who did not have a video camera, laptop, or access to the internet. Some participants also felt uncomfortable being recorded, which due to the nature of this study was necessary, and thus

limited their ability to participate. One surprising limitation of this study was that participants with diagnosed eating disorders were excluded, which limited quite a few women from participating. This decision was made because the researchers wanted to understand how fatphobia may impact eating behaviors, and those with eating disorders might engage in behaviors that deviate from the norm and skew data. However, this was the exclusion criteria that made the majority of the participants who were not eligible for to participate ineligible, so this may be a criteria to take out in the future in order to increase participation.

Conclusions

Fatphobia is chronic, pervasive, and a type of discrimination that is societally accepted (Stoll, 2019). Fatphobia exists in every facet of society, from television and movies, to music, to advertisements, to healthcare, to shopping, to travel, to leisure, to book, and more (Strings, 2017) Fatphobia has racist origins, originating from discrimination again Black women's bodies and a desire for White women's bodies to be seen as morally correct or appealing in comparison to Black women's' bodies (e.g., Strings, 2019). Fatphobia is socially accepted because of arguments that fat people are unhealthy and need to lose weight, perpetrated and maintained by the healthcare industry based on racist, inaccurate, and outdated measurements of body mass index (BMI) (e.g., Nuttall, 2015).

Fatphobia is perpetrated by loved ones, trusted authority figures, and strangers from childhood through adulthood, and impacts women's abilities to love, respect, and care for their own bodies. Fatphobic societal beliefs combine with learned internalized fatphobia create negative mental, physical, and relational health impacts for fat women. Fat, queer women ported three major implications of fatphobia in their lives including accessibility concerns, a tendency to avoid health-inducing behaviors and enjoyable activities, and a negative relationship with food.

Engaging in intentional body work was both an act of rebellion and a type of resilience and coping with fatphobia and the associated negative consequences of fatphobia.

Table 1

Participant Themes and Subthemes

Themes and Subthemes	Theme Description	Illustrative Quote(s)
Pervasive and chronic presence of fatphobic microaggressions		
Childhood External Experiences		
Bullying in school (4)	Reports of impactful, memorable childhood bullying experiences	"Kids in school would moo at me because I was fat." (Abbie)
Fatphobic comments family members (4)	Comments made by parents and family members about the child's body size, shape, weight, or the food type/quantity that they eat	"My grandma did thing where she compared my waist measurements to hers and made me feel ashamed of my body." (Abbie)
Being forced to lose weight (4)	Intentional weight loss required of the child by a parent or doctor; sometimes included dieting, forced exercise, restriction of certain types of food, etc.	"My doctor prescribed me weight-loss pills at like 5 years old because my mom told him she was worried I was too chubby." (Lia)
Being shamed about food/eating (3)	Hurtful comments made about food choices or food quantity that induced feelings of shame for the child	"My family would make comments like, geez do you really need seconds?" (Abbie)
Adult External Experiences: Strangers, Coworkers, Healthcare Workers		
Shame from healthcare workers (6)	Experiences in healthcare where doctors, nurses, etc. made negative comments about participants' weight, BMI, or body size	"I remember my pediatrician, she like, made me cry because she said I weighed too much." (Abbie)
Microaggressions at work (2)	Co-workers suggesting diet or exercise changes for fat people; weight-loss competitions in the workplace	"Sometimes people I work with will suggest a new diet or ask me if I want to go to the gym with them." (Leng)

Suggestions about losing weight (5)	Strangers suggesting to fat people that they should diet or exercise	"...he like rolled his window down and was like, he tried to sell me like a milkshake cleanse." (Maddie)
Fatphobic comments on social media (3)	Comments made on social media platforms by strangers such as Facebook, Instagram, or TikTok that consist of derogatory remarks about a fat person's body weight or size	"This person I didn't know commented and told me I needed to go to the gym." (Jane)
Adult External Experiences: Family, Friends, Partner		
Suggesting weight loss/exercise (5)	Family members or friends imply that a fat person should lose weight, diet, or increase their exercise	"My mom like, she's worried about my health, she'll like tell me I need to lose some weight." (Jane)
Concern for health (6)	Family members or friends indicating that they are concerned for a fat person's health based on assumptions that fatness and health are explicitly separate constructs that cannot co-exist	"...if you spoke to like my one of my parents about like me being fat, that's probably where they would jump, would be concern, like about health." (Maddie)
Negative comments about body (6)	Family members or friends provide commentary about a fat person's body size, shape, or weight	"...we were like shopping and there was like this really sexy dress. And I was like, Oh, you should buy that for me. And he was like, if you lose 50 pounds, I'll buy that." (Jane)
Negative comments/shame about food choices (6)	Family members or friends make shame-based observations about a fat person's food choices or meal quantity/frequency	"I've had former family members say like, Oh, she's getting a second helping of her salad, does she really need that?" (Lia)
Internalized Fatphobia		
Learned IF from parents (5)	Parents model beliefs and behaviors associated with their own internalized fatphobic beliefs in which their children learn to also engage in these behaviors and incorporate these beliefs into their own belief systems	"So, my dad is also plus-sized but was like, is a big dieter. He's been on like the Atkins diet since I was like born literally." (Maddie)

Learned IF from medical providers (6)	Medical providers teach that having a high BMI is not good for a person's health and thus people grow to believe these ideas	"And my doctor tells me I need to lose weight (laughs) umm so she's more concerned about my health than the way I look, you know, she says how beautiful I am and everything like that." (Jane)
Negatively impact relationships (5)	Internalized fatphobic beliefs make engaging in romantic and sexual relationships difficult because of associated self-esteem and intimacy concerns	"Mostly my weight has impacted my sex-life because of my own insecurities, like not wanting to be seen as fat so turning the light off, or avoiding certain positions or trying new things or avoiding sex altogether." (Abbie)
Decreased self-esteem (4)	Internalized fatphobic beliefs create a tendency for people to feel less satisfied with their bodies	"Sometimes I feel like I have negative self-esteem or talk bad about myself." (Abbie)
Desire to shrink body/lose weight (6)	Internalized fatphobic beliefs create a tendency for people to desire losing weight or having a smaller body/different body shape	"I've spent some time trying to be a smaller energy or presence." (Leng)
Avoidance		
Healthcare		
Anticipated fatphobia from medical practitioners (4)	Fat people often anticipate that healthcare providers might shame them for their weight or suggest weight loss and thus avoid going to the doctor	"A lot of times I'll like, just avoid going to the doctor because I like don't want to deal with it." (Abbie)
Concerns about misdiagnosis (3)	Fat people report experiences where they are misdiagnosed due to their body size and thus avoid seeking healthcare	"It took me five years to get properly diagnosed with my knees." (Gracie)
Being told to lose weight/prescribed weight loss drugs or surgery 4)	Fat people learn to anticipate doctors suggesting weight loss and tend to avoid going to the doctor to avoid this	"I had a neurosurgeon try to recommend that I have gastric bypass because I was too fat and clearly, I was lying about how much I was eating." (Lia)
Previous negative experiences with medical providers (6)	Fatphobic experiences in healthcare create a tendency for fat people to avoid going to the doctor	"That was so clear, just like she looked at my body and made assumptions about what was happening based on just how I look." (Leng)

Food/eating		
Eating in public (3)	Fat people learn to anticipate fatphobic microaggressions and thus avoid eating in public	"I am cognizant of what I eat in public. If I eat in public. There was a very long time that I would not go to a restaurant. Or eat in a public like cafeteria." (Lia)
Ordering food in public (4)	Fat people learn to anticipate fatphobic microaggressions and thus avoid ordering food in public	"...ordering an appetizer for the table, I'd have someone else order it because I didn't want the waiter being like, Oh, the big girl wants it." (Gracie)
Concern about eating more than others (2)	Fat people anticipate fatphobic comments and thus tend to avoid ordering more food or eating more food than others that they are eating with	"If you have ice cream and I don't, they'll think what a good job I'm doing by not indulging in something so ridiculous." (Leng)
Eating certain foods that are deemed unhealthy (4)	Fat people learn to anticipate fatphobic microaggressions and thus avoid eating foods considered "unhealthy" (carbs, fried food, sugar, etc.)	"For a long time, I went Keto and avoided eating carbs to try to lose weight." (Abbie)
Dating/Sex		
Dating someone smaller (2)	Many fat people report that they avoid dating someone who is smaller than them	"I typically date people who are bigger than me. Just so like I feel better about myself." (Gracie)
Matching with someone on a dating site who might be fatphobic (5)	Fat people reported a tendency to be vigilant about who they match with on dating platforms to avoid being microaggressed for their weight or body size	"It's like you have to have that conversation before you meet with like, hey, by the way, big girl. Hope you're cool with that. And you put the little like BBW or like whatever in your dating profiles so that people know what they're getting into." (Lia)
Dating someone who is considered societally more attractive (2)	Fat people reported that they often avoid matching with someone on dating apps or asking out someone who they deem more attractive than them	"I think that my own opinion about my attractiveness impacted who I chose to date, such as I chose to date someone who I considered in my league and vice versa." (Abbie)
Avoidance of sex (6)	Dislike and feelings of discomfort with one's own body as well as concerns about what someone else might think of their body create a tendency for fat people to avoid engaging in sex	"...I didn't really enjoy, like sex because I found it I just found it very anxiety provoking. and like, I very much would avoid anything that was the focus on me." (Maddie)

Gym/Exercise		
Going to the gym (6)	Experiences of microaggressions at the gym or while exercising created a tendency to avoid going to the gym or considering the gym with an unsafe space for fat people	"I wouldn't go into a gym. There's no way as a fat person, just no way like it wouldn't happen." (Maddie)
Exercising in public (4)	Concern about what others might think or say creates a tendency for fat people to avoid exercising in public	"…because of the fatphobia I experienced when I was jogging, I don't exercise outside anymore." (Abbie)
Concern that others think they are working out solely to lose weight (3)	Fat people don't want thin people to assume that they are exercising in order to lose weight, which creates a tendency to avoid exercise	"So just the immediate assumption being that if a fat person does exercise, they do it because they want to look different." (Maddie)
Accessibility		
Healthcare		
Being denied surgery (2)	Fat people report being denied crucial surgeries due to their body weight or BMI	"He told me I can't do back surgery on you until you lose weight." (Lia)
Being denied reproductive care (2)	Fat people report being denied reproductive healthcare because of their BMI	"...because there are no [fertility] clinics that take fat people." (Maddie)
Access to certain prescriptions, diagnoses, or treatments (3)	Fat people report that they cannot access certain treatments or have experienced misdiagnosis due to their weight or BMI	"So, it like it took so long to get a diagnosis because they kept saying, you just need to work out." (Gracie)
Seating		
Airplanes (2)	Airplane seats and seatbelts are often not big enough for fat passengers to fit in them comfortably or without additional resources (e.g., a seatbelt extender, two seats)	"I mean, you look at seats on airplanes are roller coasters. My ass is too big for that shit." (Lia)
Restaurants (3)	Restaurants often lack seating that is large enough for fat people to sit and eat comfortably	"We also might avoid some restaurants because the booth is too small, or the chairs are uncomfortable." (Abbie)

Activities (4)	Some activities such as rollercoasters, ziplining, horseback riding, etc. have weight or size restrictions that limit fat peoples' abilities to participate	"... like we avoid going ziplining or rock climbing or things where we wouldn't be allowed to participate." (Abbie)
Clothing		
Lack of stores that carry plus-size clothing (4)	Many name brand or department stores do not carry plus-size or extended size clothing that fit fat bodies	"Like, there are more clothing options available to me now, but still not the breadth of clothing options that I would like to reflect my own like identity and just comfort." (Leng)
Lack of plus-size clothing options in stores (4)	Plus-size clothing is often not carried in-store and sold online only	"Going shopping with friends at the mall was a nightmare because nothing fit so I'd just pretend to shop and then go home and order clothes online." (Abbie)
Wedding dress/prom dress options (3)	Special occasion clothing for women, such as wedding dresses and prom dresses, are often created in "standard sizing" which does not include plus-sizes	"Certain stores don't carry plus size clothing so shopping for a prom dress or homecoming dress in high school always made me cry and feel terrible about myself." (Abbie)
Food/Eating Concerns		
Dieting		
Multiple tried and failed attempts (6)	Fat women report trying and failing at losing weight or dieting starting in childhood continuing through adulthood	"I have tried just about every diet imaginable, including paying thousands of dollars for Nutrisystem meals." (Abbie)
Fasting or starving oneself to lose weight (6)	Fat women report that they have attempted to starve themselves or engage in long-term fasting behavior in order to attempt to lose weight	I tried intermittent fasting and was down to eating one hour out of every twenty four. (Lia)
Negative Relationship with Food		
Food related shame (6)	Eating foods that are considered "unhealthy" such as carbs, sugars, etc. induce feelings of shame and guilt	"In my sort of like adult life there have been a few times I've probably gone back to feeling like very ashamed about eating." (Maddie)

Tendency to binge-eat (4)	Fat women report a tendency to engage in binge-eating behaviors which includes eating large quantities of food in a small period of time	"If I shame myself for eating a lot I will binge-eat." (Abbie)
Increased emotional eating (3)	Fat women report a tendency to eat larger quantities of food in order to cope with feelings of shame or guilt	"If I feel really sad or mad, I will want to eat my feelings away." (Abbie)
Avoidance of important macronutrients (6)	Fat women report a tendency to avoid eating entire groups of macronutrients such as carbs, fats, etc.	"There have been times I've avoided eating carbs or sugar." (Lia)
Intentional Body Work		
Intentionality		
Intentional body positive work is completed (5)	Intentional body work is completed intentionally in order to feel better and achieve a greater quality of life	"Hating and disliking my body was commonplace until I made a conscious choice to put forth effort to change that mindset." (Abbie)
Work is completed as an act of rebellion (3)	Intentional body work is completed as an act of rebellion against a fatphobic society	"Like this body is a good body. but I have to fight culture to say that. It's kind of the act of rebellion we were all looking for." (Lia)
Queerness as a Resource		
Community support (3)	The queer community is considered a source of support for fat, queer women	"I feel more, I think I'm more comfortable being a queer fat person and being in the queer community because I think people in the queer community are at least on the forefront of things being more tolerant." (Maddie)
Community understanding of body liberation (3)	The queer community is deemed a safe space for fat people by fat people based on lived experience	"Queer spaces are more understanding of fatphobia and fat politics." (Abbie)
Work as a Coping Skill		
Focus on things liked/loved about body (4)	Fat women focus on things they like about their bodies rather than things they don't like as a type of intentional body work	"There are aspects of my body that I really like, like, for example, my lower legs." (Jane)

Focus on body strength (5)	Fat women focus on body strength rather than what their bodies look like as a type of intentional body work	"I think my body is strong, I think it's good. I think if you have a negative opinion of it, you need to keep it to yourself." (Lia)
Focus on what the body can do/has done (4)	Fat women focus on what their body can do/has done rather than what their body prevents them from doing or what it cannot do as a type of intentional body work	"I think in the last few years, I have spent a lot of time working on gratitude toward my body. Occasionally, excitement. I feel some pride about some of the things my body can do." (Leng)
Work as Resilience		
This work is the only way to survive (5)	Fat women feel that intentional body work is a requirement for surviving in a fatphobic society	"As a fat person it's impossible to live every day hating yourself forever or you're going t go crazy." (Abbie)
This work is necessary (4)	Fat women feel that intentional body work is necessary in a fatphobic society for a better quality of life	"Like we exist in public now. And that's not a thing I saw as a kid. But it's necessary for kids to see fat people loving their bodies." (Lia)
This work is something straight size people don't have to do (5)	Fat women report feeling frustrated that they are forced to engage in difficult intentional body work when others don't have to do so	"Thin people don't have to worry about this stuff." (Gracie)
This work is hard (6)	Fat women report that intentional body work is hard, difficult, and life-long work	It's only in the last year and a half that I have started to do the work to be like, No. I have to change the narrative in my head. (Lia)
This work is worth it (6)	Fat women report that they believe intentional body work is worth it	"I feel so much better about myself and love my body so much more since I started making an effort to change my perspective." (Abbie)

Figure 1

Fatphobia Model

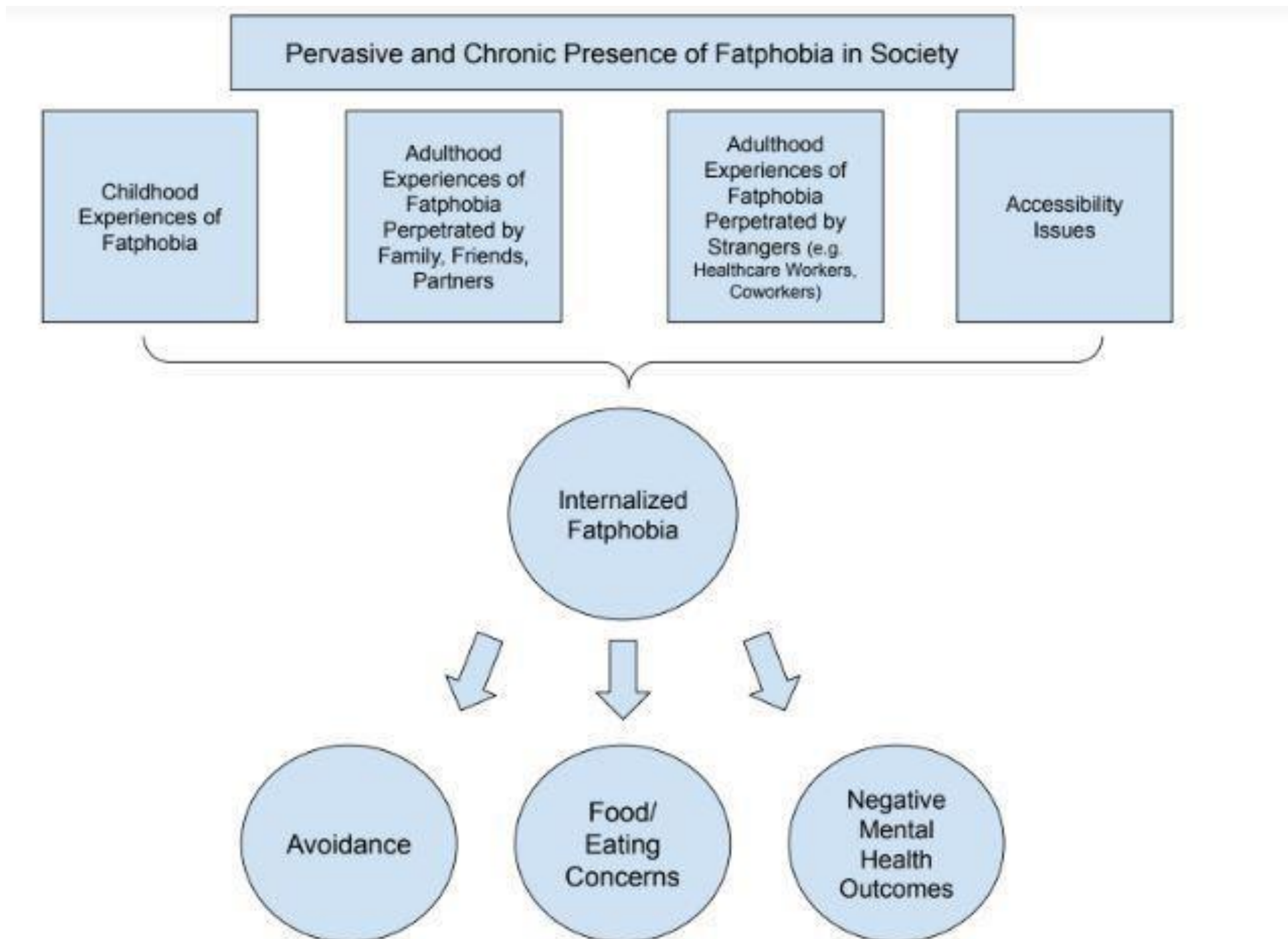
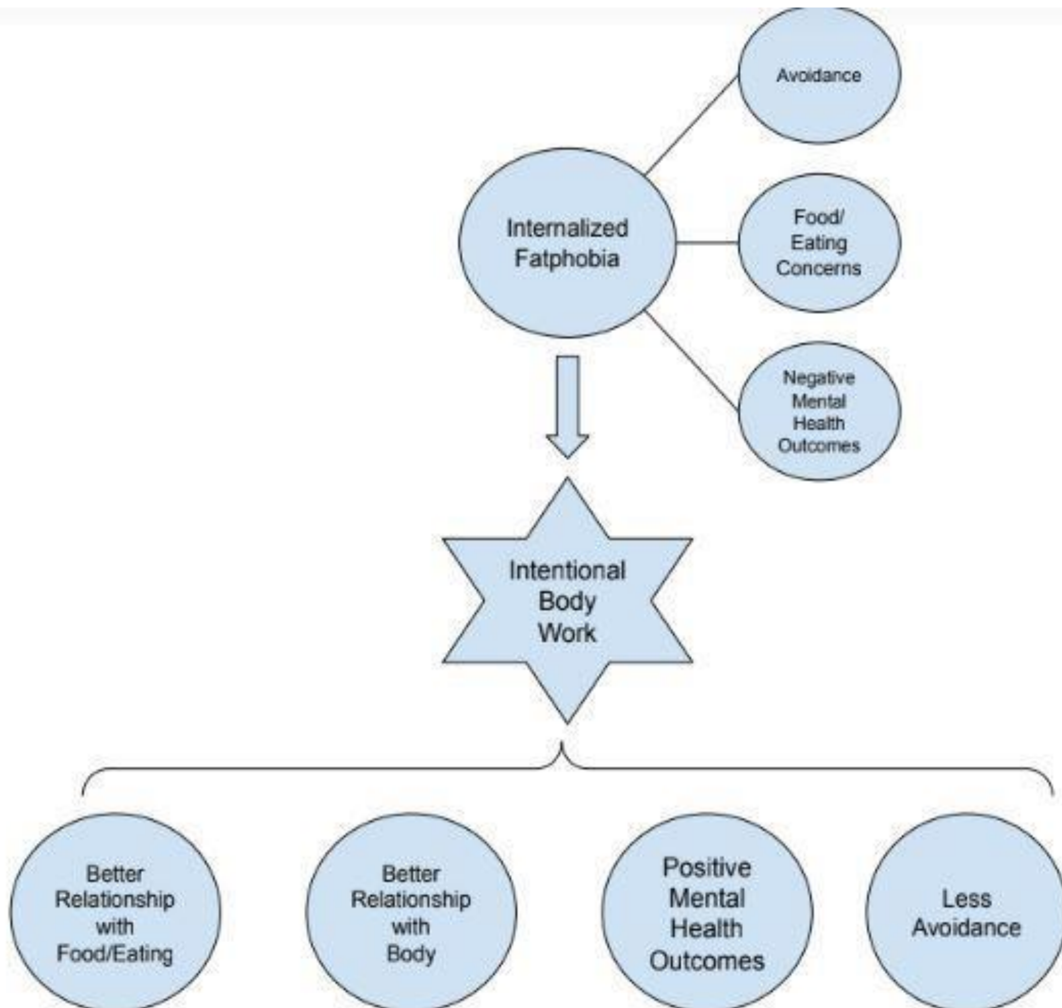


Figure 2

Intentional Body Work Model



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APPENDIX A

DEMOGRAPHIC FORM

Demographic Information

Please list a name you'd like to be called that will protect your identity, and pronouns you'd like me to use when referring to you today and in the write up of this project (Ex: Minnie Mouse, she/her):

____

Age (in years):

____

Please describe your gender identity:

____

Please describe your race and/or ethnicity:

____

Please describe your sexual orientation:

____

Please indicate your body size:

a. I identify as "straight" sized and typically wear clothes from the regular section
b. I identify as "plus" sized and typically wear clothes from the plus size section

Please indicate your relationship status:

a. I am currently in a relationship, married, or in a civil union
b. I am single and not open to dating at this time
c. I am single and open to dating, but am not currently dating
d. I am single and casually dating
e. I am widowed
f. I am divorced or separated

Statement of ability status:

a. I identify as able-bodied or temporarily able-bodied
b. I identify as having one or more disabilities
    a. My disabilities are visible
    b. My disabilities are invisible
    c. I have both visible and invisible disabilities.
c. I'd like to describe my ability status in my own words:

    ____

Highest level of education completed:

____

Current career or occupation, if applicable:

____

Your individual average yearly income:

____

State you live in:

____

Estimated population of the city you live in:

____

APPENDIX B

CONSENT FORM

Many plus size people experience fatphobia, which is a type of oppression that can directly impact a person's physical and mental health. Experts agree that experiences of oppression can impact people's relationships.

You are being asked to participate in an individual interview exploring your lived experience as a plus sized, LGBTQ+ woman. Findings from this survey will contribute to professional research literature on fatphobia, with particular emphasis on how practitioners (therapists, psychologists) can help support queer women. This study is being conducted by a Southern Illinois University Carbondale faculty member and doctoral student from the Department of Psychology.

Individual interviews will be conducted in personal at SIUC's campus, or via a professional zoom healthcare account. Interviews will last approximately 1 hour, based on a set of questions that have been pre-approved by members of a committee. Your participation is voluntary, and you may ask to stop/leave at any time.

Responses will be kept confidential, with findings compiled across individuals. Self-chosen pseudonyms will be used to refer to individuals in order to protect your anonymity. Brief demographic information will be collected to provide context for the responses, but such data will only be identified by the pseudonyms. All reports based on this research and written by the researcher will include all reasonable efforts to maintain your confidentiality.

Interviews will be audio recorded to ensure an accurate record of the ideas discussed. Recordings will be transcribed, and the recordings will be deleted upon completion of the transcription process. Quotes might be used to illustrate particular findings of this study, but such quotes will be presented in a manner that protects participants' identities by using pseudonyms.

Any questions regarding this study may be directed to: Kathleen Chwalisz, Ph.D., Professor, Department of Psychology, Southern Illinois University, chwalisz@siu.edu, (618) 453-3541 (office), (618) 203-3215 (mobile).

I hereby agree to participate in the focus group interviews.

Name:____Date:___________________

I agree to the audio recording of the interview.

Name:____Date:___________________

I consent to the use of my anonymous quotes in presentations of the finding of this study.

Name:____Date: _________________

This project has been reviewed and approved by the SIUC Human Subjects Committee. Questions concerning your rights as a participant in this research may be addressed to the Committee Chairperson, Office of Sponsored Projects Administration, Southern Illinois University, Carbondale, IL 62901-4709. Phone (618) 453-4533. E-mail siuhsc@siu.edu

APPENDIX C

INTERVIEW PROTOCOL

Participant identities and lived experience:

1. What words do you use to describe yourself?
    a. What words come to mind when you think about who you are?
    b. How would you describe yourself to someone you just met?
2. What words or labels do you use to describe your gender? ***
    a. Some people identify themselves as a man or woman, and others use more fluid labels like genderqueer or gender nonconforming. Are there words or gender labels that you feel fit you?
    b. Do you use words like cisgender or transgender to describe yourself?
    c. What level of femininity or masculinity, both, or neither fit for you?
3. What words or labels do you use to describe your sexual orientation? ***
    a. Some people name themselves as straight, gay, or bisexual. Are there words or gender labels that you feel fit you?
    b. How would you describe your sexual attraction?
    c. Do words like queer or LGBTQ+ feel like they fit for you?
4. What words or labels do you use to describe your body? ***
    a. Some people categorize themselves as plus-sized, fat, straight-sized, skinny, large, or small bodied. Are there words or labels that you feel fit you?
    b. How would you describe your body to me?

Participant's beliefs about their body:

5. How do you feel about your body? ***
    a. What are some words or phrases that you would use to describe the emotions or feelings you have about your body?
    b. Some examples of feelings or emotions people have about their bodies might be that they love their bodies, that they feel insecure about their bodies, etc. How do you describe your emotions about your body?
6. How do other people in your life feel about your body?
    a. What have people in your life said about your body?
    b. What do you believe people in your life think about the way your body looks or how much your body weighs?
    c. How do you think other people in your life would feel about having your body?
7. How does being a woman impact your relationship with your body?
    a. Do you believe that your gender impacts your feelings about your body?
    b. Does your adherence to masculinity or femininity change the way you relate to your body?
    c. Do you believe being a woman makes your relationship with your body different than a man's relationship to his body?
8. How do societal expectations of body image and body appearance impact your relationship with your body? ***
    a. What do you believe society thinks your body should look like?
    b. What do you think society believes women's bodies should look like?
    c. Do you think there is a certain way a women's body should look?

d. Do you think your body fits these expectation(s)?

e. Does your body being similar to or different than societal expectations change how you feel about or relate to your body?

Fatphobia:

9. Describe some experiences you've had where people have made negative comments about your body when you were a child. ***
    a. Did schoolmates make negative comments about your body when you were younger?
    b. Did your friends make negative comments about your body when you were younger?
    c. Did your family make negative comments about your body when you were a child?
    d. Did a doctor or healthcare professional ever make negative comments about your body when you were younger?
    e. Did a therapist or mental health professional ever make negative comments about your body when you were younger?
10. Describe some experiences you've had where people have made negative comments about your body when you were an adult. ***
    a. Do your friends make negative comments about your body now as an adult?
    b. Do your family members make negative comments about your body now as an adult?
    c. Does your partner/girlfriend/wife/spouse/significant other make negative comments about your body now as an adult?
    d. Does your doctor or healthcare professionals make negative comments about your body now as an adult?
    e. Does your therapist make negative comments about your body now as an adult?
11. Describe some experiences where someone has tried to encourage you to change your body in some way.
    a. Has there ever been a time where someone in your life has insinuated you should eat healthier?
    b. Has there ever been a time where someone in your life has insinuated you should diet?
    c. Has there ever been a time where someone in your life has insinuated you should work out or exercise more frequently?
    d. Has there ever been a time where someone in your life has directly told you to eat healthier, diet, exercise more, or lose weight?
12. How has experiences of fatphobia changed your relationship with food?
    a. Have any of the experiences you have just told me about made you feel differently about eating, food, or nutrition?
    b. Have any other negative weight or body size related experience made you feel differently about eating, food, or nutrition?
    c. Have any of the experiences you have just told me about made you severely limiting your food intake, counting calories, or restricting certain food groups?
    d. Have any of the experiences you have just told me about made you made yourself eat until you felt sick or make yourself throw up food?

13. Have you ever had a negative experience with healthcare that you believe was directly related to your body size? ***

   a. Has a nurse or doctor ever made you feel bad about your body weight or size?
   b. Have a nurse or doctor refused to listen to your symptoms or prescribe medicine and instead told you to lose weight?
   c. Have a nurse or doctor ever insinuated that a health problem you were dealing with was a direct result of your weight or size, and could be fixed by losing weight or exercising?
   d. Have you ever been refused health treatment due to your weight or size?

14. Has your mental or physical health ever suffered due to experiences of fatphobia? ***

   a. Have any of the experiences you have just told me about made you feel depressed or anxious?
   b. Have any of the experiences you have just told me about made you have bad self-esteem, or make you question your self-worth?
   c. Have any of the experiences you have just told me about made your physical health symptoms worse?
   d. Have any of the experiences you have just told me about made your mental health symptoms worse?

Dating:

15. Have you ever had a negative experience with online dating that you believe was directly related to your body size? ***

   a. Has anyone ever made fun of you or harassed you when online dating due to your weight or body size?
   b. Has anyone ever refused to date you when online dating due to your weight or body size?
   c. Has anyone ever unmatched with you when online dating due to your weight or body size?
   d. Have you ever avoided matching with, swiping on, or asking to go out with someone due to their bio being unfriendly towards fat people?
   e. Do you feel the need to have pictures that show your body or make it known that you are fat in your online dating bio?

16. Have you ever had a negative experience with in-person dating that you believe was directly related to your body size? ***

   a. Has anyone ever made fun of you or harassed you when dating due to your weight or body size?
   b. Has anyone ever left a date or refused a second date due to your weight or body size?
   c. Has anyone ever broken up with you due to your weight or body size?
   d. Has anyone you were dating ever refused to introduce you to their family or friends due to your weight or body size?
   e. Have you ever avoided dating someone or asking someone out because you believed they wouldn't want to date someone who is fat?
   f. Has anyone ever physically or mentally harmed you while dating due to your weight or body size?

17. Have you ever had a negative sexual experience that you believe was directly related to your body size? ***

a. Has anyone ever made fun of you or harassed you when having sex due to your weight or body size?
b. Has anyone ever left the experience or refused to have sex again due to your weight or body size?
c. Has anyone ever physically or mentally harmed you during a sexual encounter due to your weight or body size?
d. Has anyone you were dating ever refused to introduce you to their family or friends due to your weight or body size?
e. Have you ever avoided sex, worn clothes during sex, had sex with the lights off, or tried to contort your body during sex because you were afraid the person you were having sex with wouldn't be attracted to someone who is fat?

Relationship Satisfaction:

18. Describe your current relationship. ***
    a. How long have you been dating/married?
    b. Is your relationship monogamous, non-monogamous, or monogamish?
    c. What is your partner's gender?
    d. What is your partner's sexual orientation?
    e. Did you and your partner discuss roles, such as who has what responsibilities in the relationship?
    f. Did you and your partner discuss boundaries, such as the extent to which you can have sexual and emotional relationships with other people?
19. Describe how you feel about are your relationship. ***
    a. Do you feel satisfied with your relationship?
    b. Do you like your partner?
    c. Do you think your partner likes you?
    d. Do you feel safe with your partner?
    e. Does your partner feel safe with you?
20. How do you think your partner impacts how you feel about your body? ***
    a. Do you think your partner is attracted to you?
    b. Do you feel attracted to your partner?
    c. Does your partner ever say or do something that makes you feel badly about your body?
    d. Does your partner ever say or do something that makes you question their attraction to you?
21. Do you ever compare your body to your partner's body?
    a. Have you ever found yourself looking at your partner's body to see if their body is similar or different than yours?
    b. Do you find yourself worrying if you have more hair than your partner?
    c. Do you find yourself worrying if you have more stretch marks than your partner?
    d. Do you find yourself worrying if you have more cellulite than your partner?
    e. Do you find yourself worrying that you have a less attractive body than your partner?
22. Has your partner ever made negative comments about your body?
    a. Has your partner ever made you feel badly about your body?
    b. Has your partner ever asked you to change your body, such as by dieting, exercising, having weight loss surgery, etc.?

c. Has your partner ever made fun of your body?

23. How have the experiences of fatphobia in your life impact your relationship with your partner? ***

    a. Some people have expressed that fatphobia impacts their relationship with food, which makes them more irritable with or feel more distant with their partner. Is this something you've experienced?
    b. Some people have expressed that fatphobia impacts their self-worth, which makes them settle for partners, allow their partners to treat them badly, or stay in relationships longer than is healthy. Is this something you've experienced?
    c. Some people have expressed that fatphobia impacts their self-esteem, which makes them question their partner's attraction to or loyalty to them. Is this something you've experienced?

24. How do experiences of fatphobia impact your sex life with your partner? ***

    a. Some people have expressed that fatphobia impacts their self-esteem, which makes them want to have sex with their partner less. Is this something you've experienced?
    b. Some people have expressed that fatphobia impacts their confidence, which makes them want to have sex with their partner less. Is this something you've experienced?
    c. Some people have expressed that fatphobia impacts their sex drive, which makes them want to have sex with their partner less. Is this something you've experienced?

APPENDIX D

PARTICIPANT DESCRIPTIONS

Abigail

Abigail (she/they) is a White, pansexual, genderqueer woman who is 26 years old and works as a professor at a university. Abigail reports that she is a spiritual Christian but is not religious. Abigial is in a 4-year relationship with a cisgender, bisexual woman with whom she currently lives. Abigail describes herself as plus-size and fat, and mentioned that she has been fat since she was a young child. Abigail has completed a doctoral level education and reports an annual income of $60,000 per year. Abigail lives in a midwest, suburban area with a population of roughly 50,000 people. Abigail reports that they have multiple disabilities that are unrecognizable by others. Abigail has never been diagnosed with an eating disorder.

Gracie

Gracie (she/her) describes herself as a White, cisgender, bisexual woman. Gracie is 25 years old, holds a Bachelor’s degree, and works as a retail manager making approximately $35,000 per year. Gracie reports that her family has Jewish and Christian lineage, but that she does not consider herself a religious person. Gracie is in a 4-year relationship with a cisgender woman with whom she currently lives. Gracie describes herself as plus-size and large, and reports that she was not a plus-size child. Gracie currently lives in a rural area of 25,000 people. Gracie reports that she has disabilities that people may not be able to recognize. Gracie has never been diagnosed with an eating disorder.

Jane

Jane (she/her) describes herself as a White, cisgender, bisexual, Christian woman. Jane is 26 years old and works as a juvenile corrections officer. Jane has completed her Bachelor’s

degree and reports an income of approximately $40,000 per year. Jane is currently in a 3 year relationship with a cisgender man with whom she lives. Jane describes herself as fat and overweight. Jane reports that she was not a fat child, although she reports that she thought she was fat as a child. Jane lives in a midwestern city with a population of approximately 300,000. Jane reports that she does not have any disabilities. Jane reports that she has never been diagnosed with an eating disorder.

Lia

Lia (she/they) describes herself as a White, cisgender, bisexual, Agnostic woman. Lia is 33 years old and has an Associate's degree and has an income of approximately $20,000 per year. Lia currently receives disability benefits as she lives with multiple observable and unobservable disabilities that prevent her from being employed. Lia's husband is a transgender man. Lia describes herself as fat and uses labels such as mega-fat to describe herself. Lia reports that she was also fat as a child. Lia lives in a suburban area with a population of less than 100,000 people. Lia has never been diagnosed with an eating disorder.

Leng

Leng (she/her) describes herself as a cis, queer, femme, Jewish woman. Leng is 36 years old and works as a marketing analyst. Leng has completed a Bachelor's degree and reports an annual income of $50,000 per year. Leng is currently in a 2-year relationship with a transgender man with whom she currently lives. She describes herself as fat, and also feels comfortable using labels such as superfat. Leng reports having been a heavy child. Leng lives in a northern city with a population of approximately 450,000 people. Leng reports that she has multiple disabilities that are unrecognizable by others. Leng has never been diagnosed with an eating disorder.

Maddie

Maddie (they/them) describes theirself as a White, queer, genderqueer person. Maddie is 25 years old and holds a Bachelor's degree. Maddie works with disabled adults and is a freelance musician. Maddie reports their income is approximately $35,000 per year. Maddie reports that they are Agnostic. Maddie is in a 5-year relationship with a cisgender, lesbian woman with whom she lives. Maddie describes themselves as fat, plus-size, and superfat. Maddie reports having been a fat child. Maddie lives in an urban area with a population of approximately 1 million people. Maddie has never been diagnosed with an eating disorder.

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