STOICISM AS A COPING MECHANISM FOR STIGMATIZING EXPERIENCES AMONG LOW-INCOME, HIGHER-WEIGHT INDIVIDUALS

by

Alison Turner

B. Phil, University of New Brunswick, 2019

A Thesis Submitted in Partial Fulfillment
of the Requirements for the Degree of

Master of Arts

in the Graduate Academic Unit of Sociology

Supervisor: Andrea Bombak, PhD, Sociology

Examining Board: Gary Bowden, PhD, Sociology, Chair
Catherine Holtmann, PhD, Sociology
Kristi Allain, PhD, Sociology
Suzanne Hindmarch, PhD, Political Science

This thesis is accepted by the
Dean of Graduate Studies

THE UNIVERSITY OF NEW BRUNSWICK

October 2021

ABSTRACT

Weight and income stigma in healthcare experiences disproportionately affect higher-weight, low-income individuals. This thesis focuses on if and how stoicism is used to manage stigmatizing experiences among 11 higher-weight, low-income adults in New Brunswick. Participants took part in two semi-structured interviews that focused on healthcare experiences and both positive and negative places/spaces in New Brunswick. While stoicism is often seen as an ideology that is deployed by individuals to avoid negative emotions, the results from this thesis were that stoicism is more nuanced and complex. The participants each deployed some combination of stoic behaviours in response to stigmatizing experiences and places; however, no participants showed evidence of a stoic ideology as a coping mechanism. I argue that a stoic ideology is not developed ubiquitously among the participants, instead they showed evidence of stoic behaviours that can be understood through the uptake of fatphobic and neoliberal health messaging. These findings have major implications to understanding how stoicism can be deployed as separate and overlapping behaviours that still impact healthcare experiences.

ACKNOWLEDGEMENTS

I would like to first acknowledge all the participants who took part in this study, without you, these findings would not exist, and we would be no closer to understanding the experiences of marginalized communities in healthcare and everyday life. The knowledge that each participant shared is vital to the completion of this thesis.

Thank you to my supervisor, Dr. Andrea Bombak, whose expertise and critical perspective has been invaluable to my thesis and my progression as a critical weight scholar. I am extremely grateful for your ability to continuously push me and challenge my tacit knowledge and assumptions. It is thanks to your supervision and guidance that I have produced a thesis that I am this proud of. Thank you to Dr. Cathy Holtmann who has offered her insight and expertise as well. You have been instrumental in my ability to diversify and broaden my understanding of this research and my thesis is better for it.

I cannot thank my partner, Sam, enough for being there for me every step of this process. Our conversations about my work have been invaluable and having your support and insight has meant the world. From making me coffee during my writing sessions to our late-night conversations about the intersections of capitalism and weight stigma, the support you offered me is unmatched. There are no words for how thankful I am for you. To all my friends and family, your questions about my thesis encouraged me to question myself and to strive to make my work accessible and relevant to people outside of my field, I am a better researcher and scholar because of you. Knowing that our conversations sparked reflections about your own internalized biases and perspectives inspired my work and maintained my motivation. This thesis is a culmination of everyone who has inspired me and talked with me over the past two years, thank you all.

Table of Contents

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1: INTRODUCTION

Weight stigma is a well-documented phenomenon, recognized as affecting the mental and physical wellbeing of higher weight individuals, especially. In this project, I explored how stigma and stigmatizing experiences might be a catalyst for stoic behaviours as coping mechanisms using a small sample of stigmatized New Brunswick residents. For the purposes of this research, I use Link and Phelan's (2001) conceptualization of stigma. This approach to understanding stigma consists of five distinct, but interrelated parts: 1) "people distinguish and label human differences"; 2) "dominant cultural beliefs link labeled persons to undesirable characteristics—to negative stereotypes"; 3) "labeled persons are placed in distinct categories so as to accomplish some degree of separation of 'us' from 'them'"; 4) "labeled persons experience status loss and discrimination that lead to unequal outcomes"; and 5) stigmatization is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination" (Link & Phelan, 2001, p. 367). Importantly, this definition of stigma recognizes structural barriers and institutional stigma in addition to personal stigma that can act "outside of a model in which one person does something bad to another," (Link & Phelan, 2001). Mechanisms are developed in society that maintain power and the stigmatization of marginalized groups, which leads to discriminatory social hierarchies that continue to disadvantage those who are already negatively impacted by stigma.

Drawing from a Goffmanian understanding of stigma, "fatness operates as a type of […] 'physical' and 'character' stigma," (Bombak, McPhail, & Ward, 2016, p. 95). For Goffman (1963), there are three main types of stigma, "first there are abominations of the body […]. Next there are blemishes of individual character […]. Finally, there are the tribal stigma of race, nation, and religion," (p. 4). Weight stigma contains within it the first two types of stigma, character and body, or physical, stigma. Fatness is understood through negative perceptions of the body in a society that values thinness, which makes it a physical stigma. Additionally, the stereotypes associated with fatness, like being lazy, indulgent, or immoral, are forms of character stigma which are understood as perceptions of "weak will" (Goffman, 1963, p. 4). Understanding weight stigma is particularly important because "weight stigma remains a socially acceptable form of bias" (Puhl & Heuer, 2010, p. 1019). Weight stigma can manifest in numerous ways in healthcare experiences, in the workplace, in education, mass media, and in personal relationships. (Puhl & Heuer, 2010). Higher-weight individuals are stereotyped as "lazy, weak-willed, unsuccessful, unintelligent, hav[ing] poor willpower and [being] noncompliant," (Puhl & Heuer, 2010, p. 1019).

While there is an abundance of literature regarding weight stigma, the majority of it is narrow in scope, leaving a gap in understanding how other marginalized identities intersect with weight stigma, such as stigma faced by individuals living on a low income. Using a critical weight approach, this research analyzed the intersection of weight stigma and low-income stigma through interviews centering around healthcare experiences and places/spaces of acceptance and/or stigma. Critical weight scholarship counters the

dominant "obesity"[1] discourse by viewing fatness as a subjectivity rather than a biomedical disease. This approach is essential for this study as it aimed to address stigmatization and counter biased approaches to fatness through broader considerations of social justice (Cooper, 2010).

Weight stigma and low-income stigma can intersect to produce a negative compounding of stigmas (Colls & Evans, 2014; Kirkand, 2011). It is well established in health literature that income plays a significant role in health outcomes, with higher socioeconomic status (SES) associated with better health outcomes (McLaren et al., 2009). When discussing the social determinants of health (SDH), income is often declared one of, if not the most important determinant. SDH affects health due to its influences on other SDH including, but not limited to, employment and working conditions, education and literacy, childhood experiences, and physical environments (Canada, 2020; Ruckert et al., 2017). In addition to its influences on other SDH pathways, low income is related to a higher prevalence of cardiovascular disease, diabetes, and depression (Adler et al., 2016). The prevalence of these diseases follows a "social gradient: better health with increasing socioeconomic position" (Bambra et al., 2009, p. 284). However, while this social gradient is well established for many health outcomes, research shows that this gradient is complicated when addressing body weight as a health outcome. When researching the effects of SES on body weight through a

[1] "Obesity" throughout this paper is used when referring to literature coming from a biomedical approach or other dominant "obesity" discourses. Other terms (fat, fatness, higher-weight, overweight) are used interchangeably in reference to sociological ideologies of weight and fat activism.

binary gendered lens, Godley and McLaren (2010) found that in Canada, women follow the social gradient, meaning that higher body weight is typically associated with low SES, but Canadian men do not. The authors found that men with a higher body weight often had a higher income. This highlights the complexity of the relationship between weight and income, showing that "body weight is not simply a 'health outcome'," (Godley & McLaren 2010, p. 384). Instead, it is a complex personal characteristic with sociological significance that must be studied from multiple perspectives and not reduced to a health "problem".

Much of the current literature on low-income, higher-weight individuals focuses on environmental factors and reform in relation to what are known as "obesogenic environments". Obesogenic environments are "those which disrupt the body's 'natural' energy 'balance'," (Colls & Evans, 2014, p. 737). Obesogenic environment scholars seek to understand why some environments produce more fat bodies than others do. Some of this research is premised on unchallenged, classist perspectives on income and weight, including the idea that people living on a low income are necessarily less educated in terms of food preparation and diet choices. Assuming that low-income individuals are uneducated further promotes both weight and income stigma and reduces agency in terms of lifestyle choices and behaviours (Colls & Evans, 2014).

Research shows that "knowledge about health and nutrition […] functions to enact class distinctions" (Farrell et al., 2016, p. 2). In a study focused on public opinions of "obesity" in Australia, conversations around body weight and health among focus groups with individuals living in middle-high income neighbourhoods framed individuals living on a lower income as ignorant about the health implications surrounding improper

nutrition or exercise routines. However, focus groups with individuals from lower income neighbourhoods in the same Australian region centered the conversations around material disadvantages, not lack of education (Farrell et al., 2016). Higher SES individuals make negative assumptions about the education level of lower-income individuals surrounding food and exercise choices, which assumes ignorance on behalf of the lower-income individuals (Farrell et al., 2016). When ignorance is assumed, structural barriers to good health are "overlooked in favour of addressing (presumed) ignorance" (Farrell et al., 2016, p. 6).

Frequently, literature focuses on lifestyle behaviours, like diet and exercise, without challenging the elite norms of consumption and movement, further stigmatizing low-income and higher-weight individuals (Kirkland, 2011). Much obesogenic environment research is "intrusive, moralizing, and punitive" (Kirkland, 2011, p. 464) by suggesting bans on fast food restaurants in low-income neighbourhoods and higher taxation on "junk food" which may be the only accessible food for people living on a lower income. Furthermore, if people who were classified as "obese" before these reforms remain "obese", "this might be viewed as proof that their 'obesity' is the result of an unwillingness to practice healthy choices," (Bombak, 2014, p. 62). This plays into the dominant discourse that health is something that is within personal control and that people who are fat are seen as unhealthy, uncompliant, and irrational (Davies, 1998). However, many studies have proved that long-term weight loss is neither attainable nor sustainable for most individuals (Bacon & Aphramor, 2011; Bosomworth, 2012; Gard & Wright, 2005; Mann et al., 2015).

Research conducted among low-income, higher-weight individuals often does not recognize that class is a socially constructed way of categorizing people. Using low-income simplistically as a risk factor for "obesity" or in a way that reinforces classist stereotypes ignores the complex sets of social relations and practices that are a part of the low-income label (Gard & Wright, 2005). When making assumptions of the lifeways and knowledge of low-income people in research, the true risk factors for poor health are not adequately addressed. Researchers are more recently calling for a documentation of "how people narrate their everyday embodied lives in relation to their own understandings of 'health'," (Colls & Evans, 2014, p. 745). This research responded to this call for participants to talk about health and healthful behaviours in ways that are meaningful for them.

This research project analyzed specific coping mechanisms for stigmatizing experiences in healthcare and in the broader social context of New Brunswick using data initially collected as a part of Dr. Andrea Bombak's study on intersectional weight stigma in New Brunswick. Literature suggests that several coping strategies are deployed when individuals are managing stigma (Monaghan & Hardey, 2009; Welsh, 2011; Bombak et al., 2019; Thille, 2019). However, Himmelstein, Puhl, and Quinn (2017) as well as Thille (2019) found that there are still many gaps in the literature addressing stigma coping strategies, particularly for those experiencing intersecting stigmas. This research addresses that gap by looking explicitly at those who are both low-income and of a higher weight.

Drawing from previous literature addressing coping mechanisms as well as emergent themes from the primary data of the intersectional weight stigma study, this project

explored the effects of stoicism on coping mechanisms addressing stigmatization. Stoicism is often understood in literature as lacking emotional involvement and expression as well as exercising emotional control or endurance (Moore et al., 2012). Yong et al.'s (2001) foundational research on stoicism in healthcare experiences focused on older adults' pain responses. Yong et al. (2001) found that older adults were more likely to be stoic in painful experiences, citing social desirability as a major motivation for stoic response. More recently, research surrounding Indigenous children's coping mechanisms in healthcare experiences found that children used stoicism to cope with pain management and that these stoic patients reported feeling unheard, stereotyped, and frustrated when seeking care (Latimer et al., 2014).

There has been a new push from Pathak et al. (2017) to redefine stoicism as an ideology rather than a set of behaviours. Pathak et al. (2017) distinguishes an ideology as a "a belief system which informs one's attitudes and actions," (p. 3). A stoic ideology includes "ideals of taciturnity and self-sufficiency" (Pathak at al., 2017, p. 1), which creates expectations on how people should and should not behave. In the biomedical world, this translates to individuals being more likely to "avoid or delay seeking medical intervention for serious signs and symptoms of disease" (Pathak et al., 2017, p. 3). Pathak et al. (2017) aimed to illuminate the impact of stoicism as a system of self-regulation on health in a study with 390 American adults using a 24-point stoic ideology scale. The study found that some stoic patients had negative health outcomes, including avoiding or delaying seeking care for serious health problems. Pathak et al. (2017) also found that integrating the theory of stoic ideology in health research can help explain health seeking behaviours and improve communication. However, Pathak et al.'s (2017) interpretation

of a stoic ideology remains vastly biomedical in nature. Moore et al. (2012) called for a distinctly sociological exploration of stoicism, stating that "stoicism has largely been overlooked in the sociology of health and illness" (p. 160). A sociological approach to researching stoicism as a coping mechanism will address the reasoning behind stoical behaviours and account for the sociocultural factors (like weight, socioeconomic status, and stigma in this project) that must be considered when researching stoicism (Moore et al., 2012).

In conducting this research and analysis, it became clear that the findings would be best divided into a section about the PAQ-R stoic subscale themes and a second findings and implications section about the research questions that are posed in this project. The findings and discussion sections will be divided in this way to ensure a depth of analysis that would not be present in a traditional thesis format.

CHAPTER 2: THEORETICAL BACKGROUND

For the purposes of this research project, I use a symbolic interactionist theoretical lens while also borrowing concepts from emotion theory, such as the protection of self-conception. These theories and concepts aid in understanding stoic personal ideologies that have been developed by sociocultural influences like income and weight stigma. I also use concepts that derive from critical weight studies, stigma-based research, stoic philosophy literature, intersectionality theory, neoliberalism, and Marxist/materialist theory.

This research adopted a critical weight studies approach. Critical weight studies and fat studies are critical approaches to the dominant, biomedical "obesity" discourse (Cooper, 2010). Fat studies incorporates social justice concerns in academic work and, importantly, highlight the lived experiences of fat people. Critical weight studies scholars reject the view of a fat body as always pathological and diseased. As a discipline, it problematizes the lay and medical perspective on the "obesity epidemic," by demonstrating where the scientific evidence surrounding the "obesity epidemic" is overlain with moral assumptions. Such moral assumptions include the idea of having "good" or "bad" exercise and eating habits, or fat people being lazy and having poor character. However, critical weight scholars attempt to highlight that the dominant rhetoric may be more inconsistent than expected (Gard & Wright, 2005). This approach uses social theory, such as intersectionality theory, to focus on lived experiences and acknowledge an "individual's personal story, their community, historical time and their own beliefs and outlook" (Moore et al., 2012, p. 163).

Intersectionality is a concept that originates from Black feminist scholarship (Crenshaw, 1989). Intersectionality highlights how previous understandings of discrimination "condition us to think about subordination as disadvantage occurring along a single categorical axis" (Crenshaw, 1989, p. 140). Additionally, the intersectional experience is not summative, meaning its impact amounts to greater than the sum of each single marginalization (Crenshaw, 1989). Since its origins, "it has become commonplace within feminist theory to claim that women's lives are constructed by multiple, intersecting systems of oppression" (Carastathis, 2014, p. 304). Intersectionality aims to address the impossibility of giving one marginalized identity primacy during research and lived experiences. Being able to understand identity as multi-faceted and complex allows for deeper critical analysis of the lived experiences of participants. For this reason, it is activist in nature, similar to a critical weight studies approach, which also centers social justice and the lived experiences of marginalized people. Additionally, intersectional research emphasizes a non-additive approach, meaning that it recognizes the fact that multiple aspects of an individual's identity are not experienced separately, and they do not necessarily each hold their own amount of privilege or oppression. Instead, the lived experiences of multiple oppressions intersect in complex ways in day-to-day life (Windsong, 2016).

Symbolic interactionism operates on the basis that the social world is created by meanings that arise out of interactions between individuals. According to Blumerian symbolic interactionism, there are three key premises on which the theory operates: 1) "human beings act toward things on the basis of the meanings that the things have for them," 2) "the meaning of such things is derived from, or arises out of, the social

interaction that one has with one's fellows," and 3) "these meanings are handled in, and modified through, and interpretive process used by the person in dealing with the things he encounters," (Blumer, 1969, p. 2). In symbolic interactionism, it is imperative to understand the conception of the self. The individual must have a sense of self that is conceptualized in relation to the "generalized other" (Blumer, 1969). For Cooley (1964), the self is inseparable from society and the contextual environment, both of which impact how the individual portrays the self. These are important key concepts in talking about self-preservation in relation to stigma as it connects the social to the self in a way that accounts for its impact.

Preservation of self is a concept that is tied to stigma management. Preserving the self can be done by performing actions, which present the self to others in a particular way depending on social and contextual factors (Goffman, 1959). Additionally, in the development of the self the individual acts self-consciously to make sense of the social structures they are a part of and act accordingly (Cooley, 1964). This is tied to the development of a stoic personal ideology as stoicism can be seen as a "system for self-regulation rather than a behavioural or personality trait" (Pathak et al., 2017, p. 3), which is similar to the process of understanding social structures and acting accordingly in Cooley's (1964) development of the self. Individuals have a stake in what others think about them and therefore act in a way that indicates how they should be treated by the social audience, particularly in a way that is beneficial to the individual. However, "if the self cannot be easily changed its integrity must be protected," (Burke & Tully, 1977, p. 893). People will change behaviour according to others' perceptions of the self to protect themselves. When researching stigmatized people, it is important to account for the fact

that they may purposefully give the impression that they are a kind of person who should be treated in a non-stigmatizing way. Additionally, when the self cannot be changed to protect itself from negative perceptions, individuals then develop strategies to cope with the stigma that is associated with the self.

Emotion theory can be used to explain why people cope with stigmatizing interactions and perceptions. Bericat (2016) states that "individuals, at all times, try to confirm both the image they have of themselves (self-concept) and the particular identities through which they act in any specific social interaction (role-identity)," (p. 499). This is done because when the self is confirmed, there is a positive emotional feedback, but when self-conception is not confirmed, there are negative associated emotions. Turner and Stets (2006) explain that to avoid negative emotions, individuals may employ control strategies that reconcile a self that is not in line with the responses of others, including changing behaviour in order to receive positive feedback from others. This behaviour change could, in some, lead to a development of stoic behaviours.

Stoicism is often seen as an "imperviousness to strong emotions," (Pathak et al., 2017, p. 1). Historically, stoicism was developed as a philosophical school in ancient Greece. One of the core concepts of stoicism was to be free of the *passions*, which can be more modernly understood as being free from anguish or suffering (Moore et al., 2012). More recently, the concept of stoicism has been used widely in pain related health research, especially among older adults (Arber, 2004; Cagle & Bunting, 2017; Gillsjo et al., 2020; Moore et al., 2012; Yong, 2006; Yong et al., 2001). Many people relate behaviours such as "blocking out pain" and keeping a "stiff upper lip" with stoicism, which can result in suboptimal pain management due to under-reporting of symptoms and

subsequent lack of treatment (Cagle & Bunting, 2017). Much of the existing research around stoical behaviours center around the experiences of older adults since there is a conception that these behaviours are generationally produced. However, Moore et al. (2012) suggest that stoicism is not solely generational, but it is determined by an individual's personal story, influenced by "environment (place), employment type and community" (p. 164). In some literature, researchers have found that stoicism is prevalent amongst low-income individuals, resulting in a "self-reliance" effect that is used as a coping mechanism (Moore et al. 2012).

Stoicism in health has been noted as a coping mechanism for dealing with stigma and negative healthcare experiences (Pathak et al., 2017; Latimer et al., 2014). When using stoicism as a concept, it is vital to understand what the cause of stoical behaviours may be. When an individual is stigmatized, "the stigma or mark is seen as something *in the person* rather than a designation or tag that others affix to the person" (Link & Phelan, 2001, p. 366). This is especially true for people of higher weights who do not have the ability to choose when they disclose their discrediting identity, forcing individuals to be directly confronted about their stigmatized body, reifying their stigmatized status (Kaufman & Johnson, 2004). Individuals with stigmatized attributes often engage in stigma management strategies to negotiate their self-view. Symbolic interactionism therefore provides a strong theoretical background upon which to understand the complexities of identity development and negotiations by stigmatized individuals (Kaufman & Johnson, 2004). In negotiating identity, individuals are likely to be motivated to "act in a way that will produce self-verifying information from the environment" (Kaufman & Johnson, 2004, p. 812). This is done to avoid some of the

potential social and emotional side effects that exist as part of a stigmatized group, including very concrete forms of inequality in daily interactions as well as structural oppression/discrimination (Link & Phelan, 2001). The stigmatized individual in healthcare experiences is then left with a dilemma of going undiagnosed/undertreated or risking the social side effects of being diagnosed/treated. Avoiding healthcare or refusing to seek help become very rational choices when compared to the possibilities of losing independence or social/emotional wellness due to negative stereotypes and assumptions (Moore et al., 2012).

To understand how stigmatizing healthcare can continues to operate in Canada, I used the concept of neoliberalism in a specific health context. For McGregor (2001), neoliberalism has three main concepts, which I used throughout this research. The three major tenets of neoliberalism are 1) individualism, 2) free market via privatization and deregulation, and 3) decentralization (McGregor, 2001). While all three tenets are present throughout this research project, the concepts of individualism and free market via privatization and deregulation are most prominent. Individualism refers to neoliberals replacing "the concepts of public good and the community with individual responsibility," (McGregor, 2001, p. 84). This manifests in the idea that individuals are responsible for their own solutions to lack of healthcare and ignorance or dismissal regarding systemic barriers that make healthcare inaccessible for marginalized people, especially those living on a low income. The push for a free market by neoliberals has major implications for social services, including healthcare. Such a focus on privatization and deregulation interferes with government policies that protect against poverty, food insecurity, and other social inequities (McGregor, 2001). These free markets are seen as

the “normal, natural, and preferable way of organizing most forms of human interaction, not just economic transactions,” (Shrecker, 2016, p. 952). Neoliberals also push for a decentralization of social services that rely on a supply and demand system. In healthcare specifically, this manifests in seeing patients as consumers who are responsible for their own healthcare services and access to them. Overall, neoliberals “arrange for the public healthcare system to become so inaccessible, undependable and inefficient that people feel they are making a good consumer choice by buying services in the marketplace,” (McGregor, 2001, p. 87). This has major implications when considering the other systemic barriers that make healthcare so inaccessible already. When individuals are seen as the main drivers behind their healthcare experiences and healthcare organization, those whose healthcare is not prioritized, like higher-weight, low-income individuals, are disproportionately disadvantaged in healthcare policy.

Finally, it is important to note that my research takes a materialist, rather than an idealist, perspective. A materialist perspective espouses that the material conditions of society are the driving forces behind human progress. Essentially, “the basic premise of historical materialism is that the ultimate source of human development is the development of the productive forces” (Woods, 2016). Without the understanding of materialism, one might assume that history progresses based entirely on the ideals of prominent historical figures that push the progression of society along. Contrary to this, materialist discourses unpack the development of capitalist and neoliberal ideals in society, which leak into healthcare and other aspects of life. This is an important perspective to take as it recognizes that human “nature” is a product of the material conditions that we all live in (Woods, 2016). Taking this perspective, it is possible to

understand that changing material conditions, particularly of capitalism, can change the dominant discourses around healthcare, fatness, and income. It is not necessary to wait for an ideology to take hold in society; in changing the physical conditions of education and healthcare, the popular discourses will evolve and change alongside them.

My research aimed to find whether a stoic personal ideology is developed by higher-weight, low-income people experiencing stigma to avoid negative emotions related to a non-confirming perception of the self. Emotion theory assumes that individuals will adjust their behaviour to avoid negative emotions in favour of positive emotions. However, rather than adjusting behaviour in favour of positive emotions, employing stoic behaviours can be used to avoid negative emotions in favour of a neutral or apathetic response. That is, in favour of a non-emotional response, as being stoic is often seen as being apathetic or having a limited response to feelings and emotions (Pathak et al., 2017). Based in this theory and using a symbolic interactionist approach, drawing also from emotion theory and the concepts of stoicism, I anticipated that some higher-weight, low-income people develop stoic behaviour patterns that lead to apathetic responses in non-confirming reactions to their self-conception. In this research, I analyzed if and how these stoic behaviours and identities are used to avoid stigmatizing healthcare experiences.

CHAPTER 3: METHOLODOLOGY

Research Questions

The purpose of this study was to explore how a stoic ideology is used as a coping mechanism for stigmatizing experiences among higher weight individuals who are living on a low income. This aim emerged from the data during preliminary analysis. I addressed three specific questions:

1) How do stigmatizing experiences affect the development/adoption of a stoic ideology amongst higher-weight, lower-income individuals?
2) How does this coping mechanism affect health seeking behaviours and healthcare experiences?
3) How do stigmatizing places and spaces affect the deployment of stoic behaviours?

Methodological Overview

This study uses data that were collected for Dr. Bombak's weight stigma and health inequities study. That study used a multi-sited ethnography and included 55 participants within 5 subgroups. The overall study from which my sub-analysis emerged was designed to answer the following research questions:

1) What are the experiences of stigma among the following groups of persons of higher weight: i. Older adults, ii. Low-income Canadians, iii. Francophone Canadians, iv. Newcomers to Canada, and v. Sexual and gender minorities?

2) What are the recommendations for healthcare delivery and programming among these groups?

3) What are recommendations for improving access to healthcare delivery and health-promoting environments among these groups?

The specific aim of my sub-analysis was to use data from this broader study to understand how stoicism might be used as a coping mechanism for stigmatizing experiences in healthcare. This research used data collected from the subsample of low-income, higher-weight individuals when I began to recognize this emergent pattern during my work as a research assistant.

As a research assistant, I completed a portion of the primary data collection alongside a research team. Purposive sampling was used to recruit individuals using posters, social media, and print/radio advertising. For the low-income subsample, the sampling criteria was set to include New Brunswick adults who have been classified at some point in their lives as being "obese" (body mass index [BMI] ≥ 30) and who have an income below Statistics Canada's definition for income adequacy (lower income). The following table was used for recruitment purposes:

Table 1: Household Income

# of people in household	Annual Income
1 or 2	$14,999
3 or 4	$19,999
5 or more	$29,999

The above criteria for income adequacy were determined from Dr. Bombak's study, derived from Statistics Canada's data.

The study aimed to include ten low-income participants for two face-to-face, semi-structured interviews each at 2-3-month intervals with participant observation. During the course of the study, one participant did not complete a second interview, requiring recruitment of one additional participant, meaning the final sample included 11 participants (n=11) and a total of 21 interviews. The participants were predominantly women (n=8) with two men in the sample and one non-binary participant. Ten of the participants were white and the ages varied from 20-56 at the time of data collection. The interviews were completed by multiple research assistants working on the project simultaneously, based on who was available to interview. I completed a total of 17 interviews and two other research assistants completed the remaining 4 interviews.

The first interview centered around weight and low-income stigma and their intersections specifically relating to healthcare and New Brunswick as a whole. The second interview addressed how places in New Brunswick affect participants' overall wellbeing. During this phase of interviews, participant observation was completed at a place that participants found relevant and meaningful to their overall wellbeing. Some places that were visited included shopping malls, grocery stores, food banks, recreational centers, and other community spaces. This type of ethnography is classified as a multi-sited ethnography, which is important in order to identify "the range of settings where a problem situation currently occurs" (LeCompte & Schensul, 2010, p. 36). Additionally, a multi-sited ethnography allowed for the collection of data to be relevant to the participants' lived experiences. Ethnographic studies should be used to research what "participants' behaviours mean to *them* rather than what meaning might be imposed upon them by outsiders regarding those behaviours" (LeCompte & Schensul, 2012, pp. 47-8).

This allows for participants to give their preferred impression to the research team, giving more information about their desired self-presentation, which is connected to the symbolic interactionist theoretical framework.

Field notes were taken during participant observation of both interviews, with a larger focus on more detailed field notes during the second interview regarding places in New Brunswick. The field notes were written using Geertz's (1973) understanding of thick description as well as techniques described by Emerson, Fretz, and Shaw (2011). The data from the interviews were transcribed verbatim using a professional service and organized using the NVivo 12 software. The transcripts were analyzed using thematic content analysis with a focus on stoical behaviours.

Ethnography

As a research design, "ethnography is a qualitative design in which the researcher describes and interprets the shared and learned patterns of values, *behaviors*, beliefs, and language of a *culture-sharing group*" (Creswell, 2007, p. 68). Historically, this has been done primarily through participant observation. More recently, "a number of ethnographers recognized the limitations of participant observation as the sole means of accumulating and conveying ethnographic knowledge and began to evolve new, more rigorous approaches to data collection" (LeCompte & Schensul, 2010, p. 19). This led to the expansion of ethnography to include subtypes that coincide with theoretical positionings, such as symbolic interactionism (Creswell, 2007). As cross-disciplinary ethnographic studies became more popular, shorter, more focused ethnographic studies

developed (LeCompte & Schensul, 2010). In particular, for graduate thesis work, a full-scale ethnography is typically not feasible (Bryman & Bell, 2019).

Dr. Bombak's weight stigma study was designed as an ethnographic study, more specifically as a micro-ethnography. Micro-ethnographies do not require lengthy time in the field and rely on learning about everyday experiences explicitly. Since ethnographies rely on "researchers interact[ing] with the people they are studying, listening to what they say in conversation and asking them questions" (Bryman & Bell, 2019, p. 217), many ethnographies, including the weight stigma study, utilize in-depth interviews for further insight and data collection. For my thesis research, secondary analysis was completed with the data collected through intersectional, in-depth interviews.

In-Depth Interviewing

To understand intersectional interview techniques, it is necessary to first understand the basic tenets of in-depth interviewing. In-depth interviews combine both structure and flexibility (Legard, Keegan, & Ward, 2003). This is particularly true for semi-structured interviews in which "the researcher has a list of fairly specific topics to be covered (an *interview guide*), but the interviewee still has a great deal of leeway in deciding how to reply" (Bryman & Bell, 2019, p. 241). Completing the interviews for the entire project required the interviewers (myself and the other research team members) to be reflexive and use probes and prompts to adequately gather data about the lived and meaningful experiences of the participants. This approach is known as a creative approach, which encourages long and often repeated interviews that focus on the everyday life of the

participant (Legard, Keegan, and Ward, 2003). The use of semi-structured interviews gave participants the opportunity to speak about their most relevant lived experiences.

Intersectional Interviewing

Intersectionality originated as a framework to explore the experiences of women of colour who face both gender and racial oppression (Crenshaw, 1989). Crenshaw (1989) developed our current conceptualization of intersectionality to understand the life experiences and subsequent discrimination and oppression of multiply marginalized individuals. According to Windsong (2016), intersectionality has been expanded to include multiple intersections of marginalized identities, allowing it to be used as an interview technique that addresses multiple social identities. Windsong (2016) emphasized two techniques for intersectional interviewing. The first technique is to use purposeful sampling to access the specific lived experiences of participants. Secondly, in intersectional interviewing, it is necessary to create specific questions relating to the intersecting identities that remain open-ended to allow for participants to share what is most meaningful to them (Windsong, 2016). The intersectional weight stigma study used both techniques by interviewing people based on particular sampling criteria which ensures access to specific lived experiences and by asking questions related to both weight stigma and income stigma separately and following up with prompts and probes to address their experiences at these intersections.

Intersectional interviews emphasize participants' stories and give precedence to what they think is relevant as part of their own narrative (Christensen, 2012). Therefore, it is important that researchers remain open-minded to emergent concepts and theories

(Cuádraz & Uttal, 1999). This has impacted my research goals as it was through being open-minded to emergent concepts and theories that allowed me to observe patterns of coping mechanisms, like stoicism, that were not directly addressed in the interview questions. By being reflexive and mixing structure with flexibility, I was able to address those emerging themes during the interview process to access rich and important data.

Field Notes

Field notes are a very important aspect of participant observation and ethnography. According to Emerson, Fretz, and Shaw (2011), "ethnographer's central purpose is to portray a social world and its people" (p. 248). Ethnographies require the "reconstruction of a complex set of cultural characteristics," and therefore require multiple sources of data (LeCompte & Schensul, 2010, p. 144). Field notes can be used as a rich source of data if they are taken properly. Emerson, Fretz, and Shaw (2011) state that fieldnotes should include "concrete details rather than abstract generalizations" (p. 250) through the strong use of adjectives and adverbs to fully detail every scene. Geertz (1973) coins the term "thick description" for this, interpreting the scene and describing it down to the most immediate observations, taking nothing for granted. Thick description is essential for understanding stratified social structures that are known as cultural categories (Geertz, 1973).

When writing field notes, it is essential to create descriptions in terms of the construction we place upon the scene rather than in terms of the culture itself, since ethnographic writings are always an interpretation of the culture (Geertz, 1973). In order to accurately represent the interpretations, the scene must be described down to the most

immediate detail and even brief notes should be taken as quickly as possible and filled in more substantially when the researcher has time later that day (Bryman & Bell, 2019; Geertz, 1973). This technique, along with others outlined above, was used during participant observation since I was not writing field notes in the moment. I wrote down quick, but detailed notes that I added to when I had the time later that day to make sure I was not rushing through the process. These field notes were not used as primary data during the analysis; however, they provided important contextual information that was used to better understand the content of the interview. Fields notes were vital in understanding the mood and intent from the participants that could not be captured in the transcriptions alone. For example, the field notes were used to understand if participants were hesitant to discuss stigmatizing experiences or not, which was helpful in recognizing certain stoic behaviours that will be explained later.

Data Analysis

The two face-to-face interviews for each participant (total 21 interviews) were audio recorded and professionally transcribed verbatim. Data were organized using the NVivo 12 computer software program. Using the NVivo 12 program encourages researcher reflexivity, dense coding, and organization of data, which makes it easier to identify emerging themes and concepts (Bringer, Johnston, & Brackenridge, 2006).

When collecting the data, the research team met to discuss recurring patterns in the data. These patterns were noted and used as codes in the NVivo 12 program. Using the NVivo 12 computer program allowed for better organization of the data. Through this

program, I was able to group coded themes together to compare patterns within each theme and amongst other themes while conducting a form of thematic content analysis.

Thematic content analysis aims to discover and analyze themes from the data. Themes are abstract, interpreted meanings or patterned responses that relate to a research question (Kiger and Varpio, 2020). Ryan and Bernard (2003) note that "without thematic categories, investigators have nothing to describe, nothing to compare, and nothing to explain," (p. 86). Emerging themes come from the data, meaning that thematic analysis is an inductive approach (Ryan & Bernard, 2003). Thematic content analysis is a good method for analysis of ethnographic data since it should always start by "using inductive, bottom-up searching to examine the entire [data] set for obvious smaller and larger themes and patterns," (LeCompte & Schensul, 2010, p. 161).

LeCompte & Schensul (2010) explain that the ethnographic data will always pass through the researcher's brain and that "patterns […] emerge because the researcher is engaged in a systematic cognitive process involving comparing, contrasting, looking for linkages, similarities, and differences, and finding sequences, co-occurrences, and absences," (p. 161). This means that the researcher must practice reflexivity since the analysis is based on interpretation of the results (Ryan & Bernard, 2003; LeCompte & Schensul, 2010). Researchers need to be iteratively analyzing the data both formally and informally since the clear picture of the data is not visible right away and one must become familiar with the data in order for the themes and patterns to become obvious (LeCompte & Schensul, 2010).

While inductive analysis led the preliminary coding for the broader weight stigma study, my research project incorporated concepts from Iterative Thematic Inquiry

(Morgan & Nica, 2020), which incorporates a more deductive approach to thematic coding. For Morgan and Nica (2020), "preconceived beliefs will be the basis for stating the initial set of themes which will be updated continuously throughout subsequent contact with the data," (p. 3). This approach to qualitative analysis recognizes how previous knowledge about theory and social phenomena can be the basis of a rigorous data analysis.

As a research assistant, I began analyzing the primary data for the broader research study and therefore became familiar with the data and some initial themes early on. Themes in this instance refer to patterns in the data that were consistently found throughout multiple participant interviews. By going through the data line by line, I was able to identify these recurring patterns and meaning units by initially categorizing every segment of text into 'codes' – relevant categories based on repeated terms and concepts arising from the interviews and relevant empirical and theoretical literature and then subsuming these related concepts together. These related concepts were the building blocks for the emergent themes found in the data. The development of my specific research questions relating to stoicism were produced from recognizing aspects of stoicism within these themes. After finding broad emergent themes while doing primary analysis, I continued working with the data through secondary analysis with a focus on identifying patterns that are related to stoicism and stoical behaviours. I used my understanding of stoicism, informed by previous research, to develop preliminary codes to guide my data analysis. These codes were developed into themes through the use of the Pain Attitudes Questionnaire (revised) (PAQ-R) scale which I adapted into an analysis tool.

Much of the work that has been done in assessing stoicism in health research has been related to pain management. Drawing from this discipline, I used elements of the Pain Attitudes Questionnaire (revised) (PAQ-R) to inform my thematic analysis. The PAQ-R is a 24-item scale that assesses pain-related stoicism and cautiousness (Yong et al., 2003). For the purposes of this proposed research, only the items relating to stoicism were used in developing themes and categories within the data.

The PAQ-R scale was originally designed as an assessment tool rather than a tool for analysis. However, there are no available publications that address how to analyze data for stoicism. For this reason, I adapted the PAQ-R as an analysis tool to guide how I categorized and understood stoical behaviours within the collected data. There has been a thorough quantitative examination of the PAQ-R, which found the questionnaire to be suitably reliable (Yong et al., 2003). There is also support for the use of the PAQ-R amongst diverse populations (Yong et al., 2003). This questionnaire has, to my knowledge, only been used for assessing stoic behaviours related to pain. However, research shows that "chronic pain sufferers exhibit stoicism as a means to preserve self-esteem and maintain acceptance by others" (Yong et al., 2003, p. 678). These motivations are similar to those behind coping mechanisms relating to stigma and therefore the PAQ-R can be used to inform the assessment of emotional and social factors of stoicism in stigmatized groups (Moore et al., 2012; Link & Phelan, 2002). The use of the PAQ-R was fruitful in understanding stoical behaviours present among the participants.

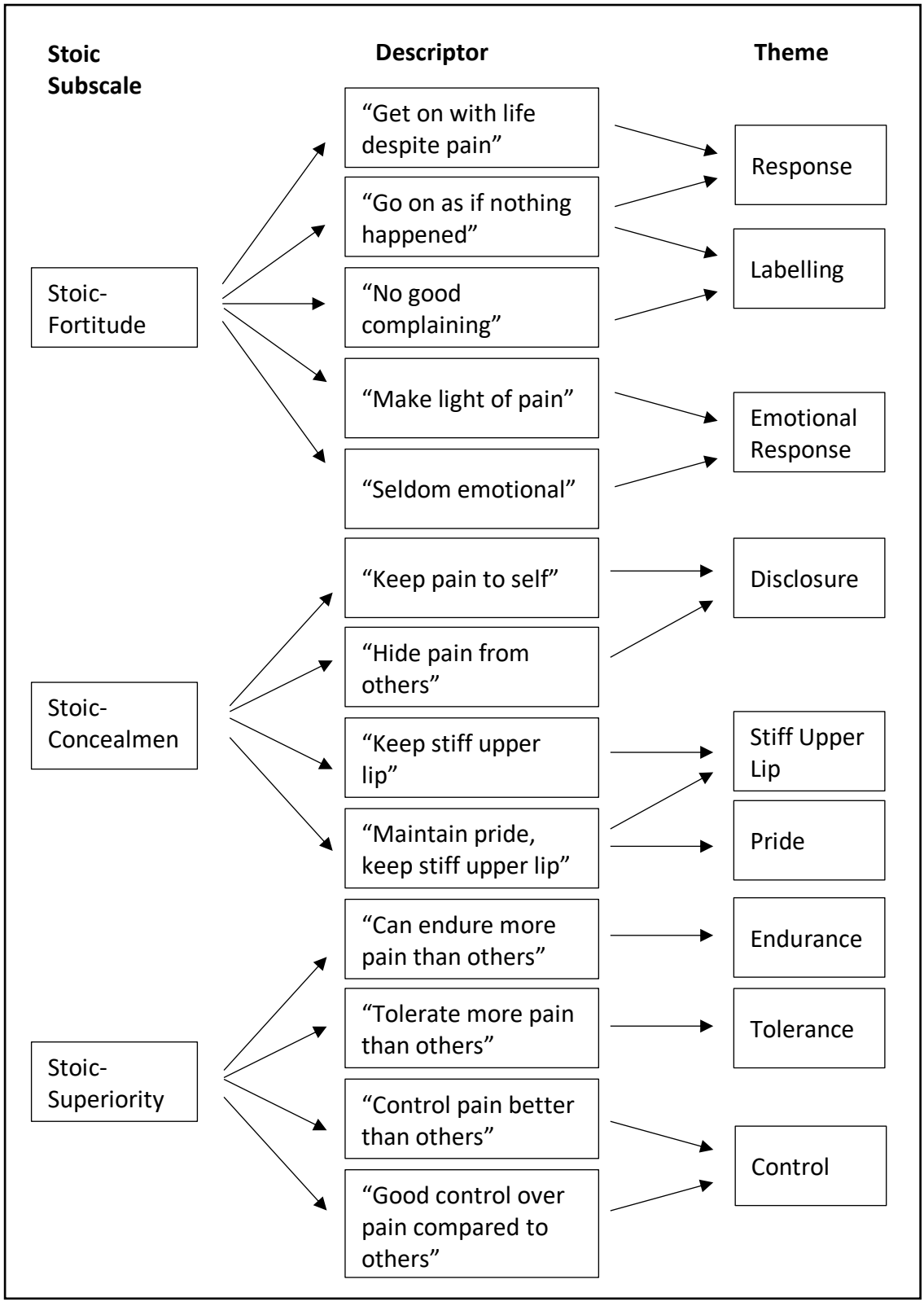
The PAQ-R assesses three main stoic sub-scales, which I used as broad categories that guided my analysis. The first sub-scale is Stoic-Fortitude (get on with life despite pain) which has four related items: "go on as if nothing has happened"; "make light of

pain"; "no good complaining"; and "seldom emotional". The Stoic-Concealment sub-scale (keep pain to self) includes items: "keep stiff upper lip"; "hide pain from others"; and "maintain pride". The final sub-scale is Stoic-Superiority, which includes "tolerate more pain than others"; "control pain better than others"; and "good control over pain compared to others" (Yong et al., 2003).

In concert with the data, these stoic sub-scales were developed into a coding framework that was used to assess the patterns that emerged through analysis. Each of these codes were used to identify instances in the data that related to the items of the PAQ-R stoicism scale. I wrote out descriptions for each item and ultimately collapsed items with very similar descriptions into broader, but less redundant, themes. This left 10 themes named using terminology from the PAQ-R that best suited the patterns that were emerging from the data (see Figure 1).

The primary themes were developed further through editing the descriptions to best match the emerging patterns in the data while staying true to the PAQ-R items. Notes were kept in NVivo memos and researcher journals. The themes that were identified in the data based on the PAQ-R items were: control, disclosure, emotional response, endurance, internalization, labelling, pride, response, stiff upper lip, and tolerance. Each of these themes will be discussed in detail in the following section.

Figure 1: Theme Development



CHAPTER 4: RESULTS & DISCUSSION

In this section, I outline and discuss the results of my thematic analysis using data collected from higher-weight, low-income individuals. Pseudonyms are used in place of participant names to ensure confidentiality for those involved in the study. For a brief description of each participant see Appendix A. I explore in depth each of the 10 themes present amongst the data: control, disclosure, emotional response, endurance, internalization, labelling, pride, response, stiff upper lip, and tolerance. Along with a description and explanation, this section includes a thorough discussion of each theme. Including an interpretive discussion along with the results of the thematic analysis will offer context and continuity for each theme. Connecting the results and discussion sections allows an immediate understanding of the relevance and fosters deeper inquiries into this specific data set that otherwise would be missing in a typical results and discussion structure.

Control

In this study, control is described as the level the participants felt that they can control their emotions or experiences, compared to others. The theme of control was partially derived from Yong et al.'s (2003) Pain Attitudes Questionnaire – Revised (PAQ-R) tool and falls under the category of stoic-superiority. Individuals who adopt a stoic attitude can be categorized as feeling superior in self-rated tolerance or control over pain compared to others (Yong et al., 2001). To better illustrate specific traits of stoic-superiority in the participants of this study, the theme of control was developed and captures attitudes such as "I have good control over my pain compared to others" (Yong

et al., 2003, p. 674) and "I rarely lose control when I'm in pain" (Yong et al., 2001, p. 284). As analysis proceeded, the description and what this theme encompasses came to include instances of participants' control of their own emotions and their reactions towards others rather than solely control over the stigmatizing experience.

Attitude control. Many of the low-income participants spoke about control in relation to their own attitude towards stigma. For many participants, controlling their attitude helped distance themselves from negative emotions related to stigma such as shame, guilt, and embarrassment. This control over attitude manifested in both formal and informal coping mechanisms. Some of the participants sought therapy or other forms of psychological or psychiatric help to control their emotions. Other participants controlled emotions without the guidance of psychological professionals. Overwhelmingly, the participants talked about their attitude in a way that follows neoliberal ideals. Monaghan, Bombak, and Rich (2018) highlighted the importance of defining how each research study uses neoliberalism as a concept to be specific and clear in meaning. In this analysis, I used the concept of a neoliberal ideology referring to its specific tenet of individualism and how it relates to health (Monaghan, Bombak, & Rich, 2018). LeBesco (2011) explained how neoliberal ideologies "responsibilize" individuals and forces the citizenry to make "good choices" for their health to avoid "obesity". Within capitalist societies, "industries make it rather unappealing to be fat, so much so that most fat people internalize this stigma and admit to a sincere desire to be thinner," (LeBesco, 2011, p. 260). This means that the state itself doesn't need to force people into thinness, but the stigma surrounding fatness marginalizes people who "opt out" of health, which is equated to thinness (LeBesco, 2011). This interpellation of neoliberal ideology

was clearly present amongst the low-income participants and manifested in controlling behaviour, attitude, and negative emotions, such as shame and guilt, surrounding their weight and perceived health. The concept of interpellation derives from Althusser's (1970) work on understanding subjectivity and ideology from a material perspective. For Althusser (1970), ideology interpellates individuals as subjects, meaning that although ideology can be understood as deriving from material conditions in a Marxist sense, subjectivity is developed through the uptake of the cultural ideology. The subject is interpellated by ideology and has an ideological recognition, which can lead to self-subjugation, where the self can only recognize itself as part of the dominant ideology (Althusser, 1970). This has important implications for this work as it demystifies the process of self-stigmatization and the uptake of dominant and often negative ideologies.

One of the study participants, Jordan, engaged in the widespread practice of judging and comparing their weight to other fat people as a young person. This practice was discussed in Nitcher's (2000) book specifically looking at the body image perceptions of adolescent girls. The author explained that teen girls often identify and talk about flaws in other girls to "strengthen their sense of self-worth in opposition to that of others in a world marked by competition," (p. 21). While this book did not assess the attitudes surrounding body image of gender diverse individuals, similar practices are likely present among other youth populations. In Jordan's interview, they talked about unlearning those behaviours, but expressed immense amounts of guilt for engaging in negative fat comparison when they were younger. Jordan saw their judgmental tendencies as a personal failing, rather than a subconscious uptake of dominant ideologies about weight and fatness in society.

> Like my childhood, like it was so rooted in like comparison to others and like being a good fat person, and like, "Well, at least I exercise," and like constantly having to justify my existence to these people who wanted to hate me regardless. […] But I still like feel so much guilt over the fact that like I was so complacent in that like maliciousness towards other people and that I like played a part in it. I guess like it makes me feel better knowing that I've actively like tried to unlearn those and I am actively trying to unlearn those things. It just is like painful knowing the things that I took part in because I was taught that that was the way that it was supposed to be.

Jordan took comfort in knowing that they were actively unlearning those weight-based biases, but the guilt that they felt is rooted in personal responsibilization practices, which function to place the responsibility on the individual to make “good” choices when it comes to weight and subsequent bias (LeBesco, 2011). Jordan tried to control their attitude towards themself by actively comparing themself to others in a way that placed them above other fat people, demoralizing those who do not exercise specifically. In their adulthood, they shifted the attitudinal control from trying to place themself above other fat people to trying to control the guilt they felt by unlearning those fatphobic biases.

Other participants were less critical about how they compared themselves to others, reinforcing ideas that how they feel is their responsibility and they can control their attitude and associated emotions based on their personality or personal outlook. Ryan talked about how his personality shielded him from stigma compared to others who let negative remarks bother them.

> I guess I was bigger, but I don't think I was an extreme kind of overweight. It wasn't at that extreme that a lot of people get to. Where it becomes a concern, like I was kind of like an average at the time. Or at least I feel like it was an average because there's so many more overweight people. Like even now, I'm still good at taking care of it. So, I haven't had a whole lot of negative experiences. I try to have an open mind, positive outlook. I try to be receptive if, when someone, if someone told me that something's wrong or it's weight related, I probably would take that in stride.

Ryan did not label things as stigmatizing as readily as other participants due to his ability to control his outlook and the comparisons he made to other fat people. As a smaller fat person, he had more privilege in his interactions with people. Additionally, he claimed a positive outlook changed his perception of what others might deem a negative experience, effectively controlling his attitude relating to stigma and the situations in which he found himself. Trevor shared similar sentiments when talking about his personality as an effective stigma management tool.

> I'm fortunate to say that because …of the way my brain works… if there's something wrong with something, there's something I need to be working on. So, you could probably drop me anywhere, and if I have an issue with it, like my brain will be thinking, "Okay, you know, it's you. You're the one that needs to be figuring something out here and changing something about yourself, adjusting your sails … instead of trying to… put the blame on something exterior to you."

Trevor appeared to perceive the ability to control attitude and emotions when he talked about negative experiences and places in New Brunswick as a moral success,

suggesting that he might think that this approach is the “good” or “right way to manage negative experiences. This suggested he had interpellated neoliberal, fatphobic discourses. This subtle uptake of fatphobic discourses can help explain some participants’ use of stoic behaviours like control over attitude as well as situational and reaction control. These types of control are influenced by the uptake of fatphobic discourses, which place the individual at the epicenter of responsibility for managing fatness and weight-based behaviours. Trevor moralized his ability to view himself as a responsible subject in relation to the cultural discourse surrounding weight and responses to stigma, showing that he had interpellated the dominant ideology.

The uptake of fatphobic discourses was more overt among some participants. Judith talked about her experiences with counselling and living with a chronic illness as a higher-weight individual. She talked about her journey with chronic health conditions, how it has impacted her mental health, and how she has learned to cope with those emotions. In the interview, Judith clearly stated how every day is a struggle with her mental health, but through counselling she has learned to control her attitude towards stigmatizing experiences.

> With the mental health support, the counselors basically said, it's just, it's up you, it's really up to you as a client to say, do you want to live miserably, or do you want to try and see the joy in the world even though you've got something?

Judith illustrated how mental health support focuses on an individual’s reactions to their personal situation, rather than the structural and systemic lack of support for people living with chronic disabilities or illnesses. Much like LeBesco’s (2011) discussion of responsibilization of avoiding fatness to presumably maintain health, this

approach to mental health support may impact a person's sense of self. If an individual, like Judith, fails to see the joy or to overcome the challenges of major structural barriers, they are seen as an individual with moral failings, carries further stigmas.

Situation control. Another way that participants used control as a form of stigma management was through situational and behavioural control. Participants talked about the ability to control a situation, or not getting themselves into a situation that would be stigmatizing. If participants found themselves in a situation that was potentially stigmatizing, they would often change their behaviours to control the outcome of the situation. According to a Goffmanian understanding of stigma and stigma management, individuals act in ways that preserve their sense of self or present themselves to others in a particular way in order to control the social situation (Goffman, 1959; Cooley, 1964). This type of behaviour change that is used to protect an individual's sense of self was evident among the low-income participants who sought to control their social situations and behaviours.

Elizabeth explained how she used behavioural changes to avoid stigma. While working, she pushed her physical limits in order to present a self that would be protected from stigma and judgement by others, successfully changing others' perception of her.

> I don't want there to be reasons why I can't do things at the same level as everyone else. And I don't want to have to make excuses for myself just because of the size I am. Because I know that I can maintain my work level. It's just when you're being pushed to extremes sometimes it feels like your limit is a lot lower than some other people. Um, but I think it's mostly just myself thinking that. Because it didn't seem like anyone else was making out that it was that way.

Elizabeth saw her behaviour as something that was innate within herself rather than an expectation placed on her by others, perpetuating the dominant neoliberal health discourses discussed previously. These behaviours that were enacted to avoid stigma were very present amongst many of the participants, ranging from daily activities, social settings, and healthcare seeking behaviour. Penelope controlled her self-image to avoid being stigmatized even amongst her close family and friends. As a higher-weight person, Penelope was very cautious about her eating habits in front of people. To not be judged by her social circle, she would avoid eating in front of them or would order food that is typically deemed "healthy" or "good".

> It's even gotten to the point where I don't like it when people watch me eat too. I kind of just go home. I don't like going to restaurants because I'm like oh no, people are going to watch me eat and like... Not because I'm messy. It's just because oh, like why is she ordering that and things like that. I don't think about it a whole lot because I don't go out because of that, but when I do, I'm with my family and they're like oh no, let's go out to eat, I'm like mmm, okay. So, I don't, sometimes I don't even finish my full meal because I'm afraid of what people, other people around me are thinking about me eating.

Penelope talked about avoiding eating in front of her family, but she also avoided eating in front of her rugby team, close friends, and university peers. In her interview, Judith also talked about the moralization of food and the standards that fat people are held to in relation to their eating habit. Murray (2008) unpacks the assumptions surrounding higher-weight individuals' eating habits. Murray (2008) explains how food and eating is pathologized for fat individuals, which leads to unchallenged assumptions

that fat people cannot help themselves from eating “bad” foods. She wrote about how higher-weight individuals are judged for eating “unhealthy” foods in a way that thin people are not. This pervasive judgement was something that Penelope interpellated greatly and lead her to develop severe avoidance behaviours.

Elizabeth and Penelope exemplified situational control through avoidance and perseverance in their daily lives. For some participants, the need to control situations was more acute in healthcare experiences where they believed stigmatization is more likely. Jordan would do everything to hide their body from their healthcare providers as a way to control stigma.

> Like I for the life of me have tried so hard to avoid doctors touching me because […] like I can hide behind clothes a little bit and they can see that I'm fat but if they touch me, they can like feel how fat I am and like that just gives them another like another layer of me being vulnerable for them to criticize and for them to like marginalize me.

Jordan would engage in certain healthcare seeking behaviour but would control their level of vulnerability to avoid negative perceptions of themself. Other participants would be more extreme in their avoidant behaviours as a way to control stigma and negative emotions. After a particularly negative healthcare experience, Angela developed intense healthcare avoidant behaviours, specifically for the emergency room (ER).

> I would just take a Tylenol at home and go to sleep and hope it goes away or something like that. But that would be about it. Other than ... I probably will never go back to the ER unless I can't breathe, or my heart is failing. So that's about the only time.

Angela exemplified how far individuals go to avoid negative and stigmatizing experiences. This phenomenon is well documented in critical weight research and other research on weight stigma. Puhl and Heuer (2010) report that in a study including higher-weight women, many reported delaying or avoiding seeking healthcare due to "disrespectful treatment and negative attitudes from providers" (p. 1024) relating to their weight. Weight based stigma is also related to negative mental and physical health implications due to internalized stigma and healthcare avoidant behaviours. Angela would avoid emergency healthcare unless fatal due to negative past experiences. Other participants talked about their own healthcare avoidant behaviours. For Ryan, this avoidance stemmed from dismissal by healthcare professionals.

> Negative experiences could be a barrier because that just makes you not want to go. If you know, hey, I have this problem and I'm just going to be told to go home, I probably won't go. I've done that a lot myself. Like, oh, there's a massive pain in my side. It's like it'll go away. A doctor will tell me it'll go away, so. I just won't bother.

Ryan was able to control the possibility of a negative or stigmatizing healthcare experience by avoiding going to a doctor all together. For many participants, the process of suffering through their pain was preferrable to having stigmatizing experiences in healthcare and therefore healthcare avoidant behaviours developed to control stigma in their lives. Trevor reflected on his healthcare seeking behaviours in one of his interviews.

> I mean… there is a part of myself where I will put off dealing with some type of medical issue for a while thinking that it will blow over. Like, maybe it's a sore knee or a particular sore area of my back, and… two months later it's still buggin'

> me or three months, or five months, or six months, or nine months, and I'm like, oh, this is not working. I need to go see the doctor. So… maybe there's a bit of an overlap with me and people that might do it for longer. Maybe some people will push things for a year and a half, or two years, or five years, whereas I don't push it as much. And maybe other people don't push it as much as I push it. […] Those are possibilities.

Trevor was unable to identify why he would seek healthcare or not, but ultimately presumed it was something to do with his personality. Research shows that this disparity may be caused by the prevalence of stigmatizing experiences in a person's life that impacts their health seeking behaviours as outlined above (Gard & Wright, 2005; Mensinger et al., 2018). It is not possible to retroactively determine Trevor's level of internalization of stigma, but one can posit through interpretation that stigmatizing experiences might have played a role in behavioural changes. There is significant academic and anecdotal evidence that shows that internalized and/or experienced weight stigma affects future healthcare utilization amongst higher-weight individuals (Alberga, 2019; Amy et al., 2006; Mensinger, 2018; Pausé, 2014; Puhl & Heuer, 2010).

As demonstrated above, participants found ways to control their situations to avoid stigma or judgement from others. Not all participants explicitly identified their behaviours as stigma management techniques, but many of their behaviours align with previous research on weight stigma and its effects. In many instances, stigma is directly correlated with negative health outcomes and avoidance of healthcare for extended periods of time. LeBesco (2011) explains that an interpellation of bodily shame, healthcare avoidant behaviours, and weight loss attempts can have "more deleterious

health effects than a stable but high weight," (p. 160). This shows the importance of understanding the effects of weight stigma and individuals' response through situational control.

Reaction control. The third type of control that appeared as a pattern amongst participants was control over their reactions to others' judgmental behaviours. This form of control was especially prevalent among the participants who deemed their personality as a protective factor against stigma and negative experiences. Nearly all the participants who talked about controlling other people's stigmatizing reactions talked about being the kind of person who can "call out" bad behaviours. This type of behaviour corresponds to the stigma management practice of challenging, which is a rejection of the stigmatizing label/experience and a transfer of shame or deviance to the stigmatizing person (Weitz, 2004). Angela would often call out people she thought were rude for staring or making judgmental remarks towards her or her family.

> I'm really loud when it comes to that, like I'll call people out like the ladies staring at me. I'll be like, "Can I help you with something?" Like I'll do stuff like that when I'm mad, like when I'm ready to blow. […] Well, it bugs the shit out of me. My sister hates it when I do it because we'll be at like Walmart and someone will be staring at me, and I'll be like, "Yes, can I help you? Is there something in my teeth? Like what?" And my sister's like, "Can you not do that to me?". It's like, well they shouldn't be staring.

In this situation, Angela challenged the stigmatizing individual to confront their judgmental behaviours by calling them out publicly. In this way, she rejected internalizing stigma directed at her by strangers and transferred the judgment back on the

perpetrator. She controlled her reaction towards the stigmatizing event in an unexpected way and effectively rejected the stigma. Ryan also talked about calling people out for their judgements of him. However, Ryan added complexity to this kind of control by talking about when this strategy can and cannot be used.

> Say if someone gave me a dirty look, it's like, okay, here's the middle finger. You can retaliate. When it's family and stuff like that, it's hard to, you know, be accepting of it. It just hurts in a way. As far as relationships, friends, any of that. It makes it complicated.

Ryan talked extensively in his interview about being stigmatized by his family. Ryan stated he had a harder time challenging judgment from his family compared to the judgment he faced from strangers and therefore had less control over his reactions to stigma in the context of familial relationships. However, he still attempted to control his reactions through challenging strangers with aggressive responses. Different social roles and relationships produce different ways of managing stigma for participants. Avery also claimed that her personality is an effective way of controlling stigma through her behaviours and reactions to other people dismissing her.

> I think it also comes down to personality, too. Like, I'm not someone that typically gets walked over. And, if you try to, I don't take very nicely to it. And I will call you out on it. Whereas someone who might be a little bit more timid might constantly have to go into the ER a whole bunch of times before they are properly diagnosed.

Avery brought up an important point to discuss which is how this kind of control also impacts healthcare seeking behaviours. Since Avery was able to vocalize her needs,

she saw herself as someone who was able to access adequate care through her own self-advocacy. She compared herself to others who are not able to advocate for themselves and might have to access healthcare more frequently. However, as explained before, literature shows that healthcare seeking behaviours are complex and multifaceted (LeBesco, 2011). If someone is not able to self-advocate, they may be more likely to label an experience as negative and avoid care. This shows the detrimental impact that stigmatizing experiences can have on the mental and physical health of individuals.

In addition to their own reactions, some participants attempted to control the reactions of others through behavioural changes to avoid stigma. In particular, Trevor was very aware of how he had been perceived as someone living on a low income. Trevor struggled with homelessness throughout his life and was therefore forced to confront the negative stereotypes people have about low-income and homeless individuals. This participant actively developed intensive coping mechanisms like changing his clothing style and social circle to avoid being stigmatized in his daily life. Trevor also tried to compensate for his low income through acting in a way that would make people perceive him as smart, thus controlling their reactions to him and his social standing.

> You know… I'm articulate. […] I present well. […] When I go buy things, I'm always trying to keep my brain sharp. I keep a running tally in my head. I try to calculate the taxes. I have my money ready. I know how much change I'm supposed to get. I'm watching the cash register as it rings in. […] One, one part of me says, "Maybe you'll come across as somebody that's really, really aware and really paying attention and just smart." Or maybe I'm coming across as, "Man,

this guy maybe is poor as hell and he has to watch every penny." Um, I don't know, but I think I come across okay in public.

Trevor had to be hyper aware of how people react to him and changed his behaviour accordingly to avoid stigma. This kind of behaviour was frequent amongst the low-income participants who actively change what they wear, what they eat, and how they speak to avoid income-based stigma.

Disclosure

Disclosure as a theme in this data set was present less frequently than other themes. For this research, disclosure refers to when participants decide to disclose or not disclose stigmatizing experiences. In previous research on stoicism, disclosure is an aspect of stoic-concealment. Typically, people who adopt a stoic person ideology lack willingness to disclose pain to others (Yong et al., 2003). For this study, based on this prior research, participants would therefore be expected to have a lack of willingness to disclose their stigmatizing experiences to others and to the researcher, specifically. However, very few participants were not forthcoming with their stigmatizing experiences. More often, the participants did not label experiences “stigmatizing” that I considered to be forms of stigmatization. This pattern is captured in the labelling theme. In opposition to the literature surrounding stoic disclosure, many participants were willing to share their stigmatizing experiences, likely because of their willingness to participate in the study. It is important to note that the study recruitment materials did not include the term “stigma”, however, it is possible to infer that participants’ willingness to participate in a study related to their weight and healthcare experiences meant that the

participants were more willing in general to share their negative and stigmatizing experiences. Additionally, the interview questions included asking about their treatment in general as a higher-weight, low-income individual and their most positive and negative healthcare experiences. It might be that the language used in the interviews changed how willing the participants were to talk about their negative and stigmatizing experiences. While many participants were willing to share their experiences, coding the data for the disclosure theme was still beneficial as some participants revealed to the researchers how they decide whether to disclose pain or stigma to others.

Avery talked about how living on a low income affects people's willingness to disclose personal information that might be stigmatizing. This participant highlighted how some people are not able to choose when they disclose information in order to have adequate care.

> Having the conversation that it is, for someone who does have some medical benefits but can't afford to buy over-the-counter medication, um, because they've paid into that family plan might ask their doctor to prescribe them a cough medicine, rather than go buy them off the shelf. Um, because it's cheaper. So, then, they know. And they might disclose that.

While Avery was not speaking from her own personal experience, she highlighted the complexities of living on a low income. Trevor talked about his need to disclose stigmatizing information and how that affected his care.

> Uh, like, 20 years ago, I had the really wise idea to experiment with injecting cocaine. […] Um, but one day, I was just busy with my needle, and with whatever I was trying to do with it and given that I had almost zero experience with that

> particular path, I injected myself wrong, […]. I guess it didn't go in the vein or something. It got shot in the wrong spot. Um, and so this little bump alarmed me. And then, a large area of my arm maybe about the size of a piece of squash or something, just went all numb. […] And so, I got on the bus, and I just went to the hospital. It's like, guys, I injected myself, and I don't know what's goin' on, and I'm scared. Can you check me out? And so that's in my history somewhere. It could've been possible that that popped up. You know? […] Maybe, maybe they just thought, "he's just tryin' to play us", and maybe they saw that previous history.

Trevor attempted to seek care for back pain after a history with addiction. The healthcare professionals that saw him were less willing to take his pain seriously. After disclosing his drug use history, he lost credibility and the doctor did not provide adequate care. This type of reaction to disclosing a stigmatized behaviour likely affects the development of stoic behaviours. Pathak et al. (2017) explain that while some people might have a stoic ideology, certain health needs require medical assistance. This causes "an internal resistance to external objective needs, which can lead to negative consequences," (Pathak et al., 2017, p. 6). Elizabeth talked about the complexity of disclosing potentially stigmatizing information to healthcare professionals. She saw disclosure as an important process when medical assistance is needed. When asked how healthcare access could be improved, Elizabeth talked about how individuals who are seeking care must be more willing to disclose things that might be normally seen as "embarrassing".

> I suppose just people kind of trusting that they can tell doctors what's wrong with them. Um, and just not being afraid to bring up things that might be a little bit embarrassing but are gonna help you.

Elizabeth said that disclosure can be made easier through the normalization of stigmatizing or embarrassing health conditions. She also saw disclosure as a way to achieve adequate healthcare. Angela also talked about how disclosure can be used to access adequate care. When asked if she thought her mental and physical healthcare were different, Angela explained the differences she saw and how they relate to disclosure:

> Yes, but that has nothing to do with my weight, just my traumas and everything I've been through. It's been a lot, so definitely mental health, they really ... I have a - my family has a history in mental health, so when I go in, they kind of already know what's going on and they know all the stories and everything, so they do treat me really well at mental health as well.

Angela highlighted how disclosing trauma and mental health issues to her doctor helped ensure she received adequate care. Many participants who talked about disclosure viewed it in a similar way, that it is a tool to be used in healthcare interactions. Disclosure is certainly complex; for some participants it afforded them credibility and ensured adequate care and support. However, for others, like Trevor, it can be deeply discrediting based on how stigmatized the topic of disclosure is and whether the healthcare professional has had anti-stigma training. Clearly, disclosure can be helpful in some instances and detrimental in others. Because of this, it is difficult to say whether or not these participants all have a stoic ideology, but there is evidence of stoic behaviours present among them.

Emotional Response

The theme of emotional response was developed out of the stoic sub-scale, stoic-fortitude (Yong et al., 2003). Stoic-fortitude relates to an individual's "willingness to exercise courage or fortitude in the face of pain," (Yong et al., 2003, p. 678). As part of this, emotional response refers to how participants expressed their stigmatizing experiences or related to them in an emotional way. This theme only captures emotional responses and not behavioural responses, which will be addressed later when talking about the response theme.

Stoicism is often understood as an imperviousness to strong emotions (Pathak et al., 2017). Many of the low-income participants embodied this imperviousness, often with pride. When asked about places in New Brunswick that were stigmatizing or unsafe, Elizabeth reflected on her own experiences with unaccepting spaces.

> I've had that experience, and like it hasn't affected my wellbeing or whatever but I'll just decide I'm not gonna go there anymore. And while it's disappointing to lose a spot like that that used to be great when you were a kid, I mean, I'm not suffering from it.

Elizabeth talked about distancing herself from negative places and experiences. For her, those negative experiences did not affect her overall wellbeing, regardless of previous positive associations with a particular place. This type of rationalization over negative experiences aligns with stoic behaviours and understandings of emotion. During the interviews, Elizabeth spoke to me in a way that seemed to serve to distance herself from her emotions relating to negative spaces and experiences. Whether this distance was performative for the interview, genuine, conscious, unconscious, consistent, or

ambivalently deployed cannot necessarily be distinguished with the current data, but regardless this is evidence of the adoption of some stoic behaviours, conscious or not.

Angela also showed evidence of some stoic behaviours specifically relating to stoic-fortitude. Stoic-fortitude is understood as making light of pain (stigma) or holding the belief that there is no good in complaining about pain (stigma) (Yong et al., 2003). These two beliefs were clearly held by Angela when talking about a highly stigmatizing experience in her life.

> When I was working at McDonald's, we had a group come in and they were making pig noises while I was working behind the counter. […] So, I just remember leaving and crying and everyone was like, "Oh you can go home". I was like, "Just give me a second." I was like, "They'll be gone in two minutes. They're gonna stuff their food in their face and they'll be gone, and I won't have to worry about it again." […] They were like making like barnyard noises and it was terrible. I was probably 25. It still like sits in my head. Very hurtful. And I'm pretty sure it was the prom. Like the group was kids from high school, so even looking back at it now, I'm like they're young. They don't realize yet.

Pertaining this experience, Angela talked about being severely and overtly stigmatized by a group of people at her work. While she did have an emotional response, Angela made light of it by refusing to go home and not complaining since the group of people would be leaving shortly. Additionally, Angela made light of the situation by excusing their negative behaviour through their age and presumed lack of education around the consequences of their behaviours. Like Elizabeth, Angela distanced herself from the emotions and showed evidence of stoic-fortitude ideals.

Other participants reflected on their behaviours and emotional responses to past stigmatizing experiences. During their interviews, some participants were able to admit that they distanced themselves from their emotions as a coping mechanism but were changing their relationship to stigmatizing events upon reflection. Jordan was very open with how their perception of seeking help has changed.

> I've kind of come to the conclusion that I need help. Like I've come a long way with my own like disordered eating and stuff. But I've realized that I need some help with it, um, like with a nutritionist or like something. But I am terrified to like dip my toes into that water because I know that like I will be handing my power over- like some of my power over to someone who has the opportunity to completely like break all the progress that I made by saying - like by having like fat phobic values [...]. Like 'cause I tried to get help for disordered eating in the past, and I was told that I needed to eat less and exercise more when I was already starving myself. […] I kind of like had that realization like reiterated for me in the past couple months that like it is challenging to get help for an eating disorder anyway, but it's even more challenging when you're in a body that like people don't take seriously.

Jordan explained how they were wary of seeking help and being emotionally vulnerable around professionals who hold a lot of socially legitimated power. In the past, Jordan had developed some stoic-fortitude ideals and behaviours due to negative experiences with fatphobic mental health professionals. However, Jordan stated that they need professional help, which clashes with those same stoic ideals. The clash between emotional reservation to avoid stigmatizing experiences and feeling that those behaviours

were self-destructive was a complex thing to navigate for Jordan due to their past stoic behaviours.

Penelope was also very reflective during her interviews. On multiple occasions throughout both interviews, she mentioned that the interview questions prompted her to be more self-reflective about her own experiences than she had in the past. She also tended to make light of many stigmatizing experiences but also seemed able to come to understand her own emotions relating to those experiences through conversations about them. Penelope disclosed some negative and stigmatizing experiences she had with a nutritionist during her pregnancy.

> I was a first-time mom, and so I'm like well… like I know I'm supposed to eat healthy but it's hard to so give me other options that I can... Like not just a salad, not just things that I couldn't afford which maybe she could've looked at it, like oh well, you can try going to this place and buying this or this is really good nutrition if you can find it for a good price, or just offering other options. Because yeah, I just felt shamed, that's all. It was not, I don't think she realized that, but I kept that and that was almost six years, more than six years ago now, so.

After being prompted by the interview questions, Penelope talked about shame she felt was caused by this nutritionist. At other points in the interview, she talked about how even she did not realize she was holding on to this level of shame so many years later. Penelope's experiences showed that stoic behaviours are complex and can be reflected on throughout an individual's life. Penelope used stoic-fortitude as a coping mechanism and hid her emotional response for years to distance herself from those emotions.

Judith was very open about her use of coping mechanisms to navigate living as a higher-weight individual with a chronic illness. Judith talked about her experiences with sizeism and ableism, as well as the intersections of the two in her interview. For Judith, systemic barriers to accessibility were particularly difficult while also living in a larger body. Additionally, she felt unchecked weight stigma as people would shame her for gaining weight even though she had serious mobility issues and took medication that caused weight gain. When asked about how her experiences with weight stigma and negative healthcare experiences affected her mental health, Judith talked about her journey with coping skills and how she "suck[s] it up" to remain positive.

> Um, so you learn coping skills. Um, cause every day is, is depressing, you know. […] Um, so without tapping into some type of mental health system, which is very far and few between, as you know, um, it comes down to you as a person trying to find your own resilience. And so, then I, you know, I started reading books, you know, on living with chronic diseases, about living with chronic pain, you know, and it's the same thing. It's just basically suck it up and shut up buttercup. That's it. That's really all that's out there. And the only difference is you have to put a smile on your face, or you don't.

It is important to note here that Judith developed her own coping skills through self-education since the mental health care system in New Brunswick was not meeting her needs. Judith found it difficult to seek out professional help to learn how to cope with her chronic illness and turned instead to books. She found most of the help she could find was about distancing herself from negative emotions by "sucking it up". One of the main tenets of stoic-fortitude is the belief that there is no use in complaining, which is

exemplified in Judith's explanations of her coping mechanisms.

The theme of emotional response is clearly complex and highlights that stoic behaviours can be reflected on through their life depending on what stigmatizing experiences they are having and how they cope with them at the time. This research shows that stoicism and stoic coping mechanisms may be much more fluid than previously expected and there is a benefit in understanding stoicism outside of a rigid ideological lens. This contrasts with what Pathak et al. (2017) theorized; they conceptualize stoicism as a personal ideology that is rigid and binary in nature.

Endurance

Endurance as a theme is an aspect of stoic-superiority. As a concept, stoic-superiority is best understood in relation to others. Common ideals related to stoic-superiority are being able to control pain (stigma) better than others or endure more pain (stigma) compared to others. Based on this, endurance was originally understood as how the participants feel they can deal with stigma (better or worse) compared to others. However, through coding it became apparent that this was too closely related to other themes (tolerance, control). Additionally, this original description did not capture the true nature of endurance, which has an aspect of time involved in it. The theme is better described as the ability for participants to deal with their stigma (better or worse) compared to others over time. The length of time varies widely based on participants' perceptions of endurance. In the data, two patterns emerged within the endurance theme. For some, endurance was understood in a more physical way especially relating to their weight and ability level. Many participants pushed their physical limits to avoid stigma or

judgement because of their mobility level. In other instances, endurance was conceptualized with emotions and the ability to manage intense emotions better than others over time. These two understandings of endurance were not always mutually exclusive in the participants' experiences and are likely intertwined.

Overall, emotional endurance was more prevalent than physical endurance. This is likely because the interview questions were geared towards talking about lived experiences rather than exercise norms and daily physical activities. Some participants talked about how their endurance built up based on stigmatizing experiences they had as children and youth. Judith talked about being called names as a kid and how she learned to endure that as she grew up.

> They all figure if you lose weight, you'll be healthier. Cause that has been society's […] debate, I guess, for years that overweight people are not healthy. Right. And you can understand when you talk about the BMI, you know, um, that that ratio, when you see it going, as a society, we start it in grade school. You're called fatty and tubby. Right. You're not accepted. You got buck teeth, whatever, you know the problem is right. You've got glasses you're cross eyed. Like, you know what I mean? Like those types of things. So that bullying starts at a young age in society […]. So then when we get up to, you know, high school, junior high or junior high and high school and university and life and get out on your own and you're living in the in society, it's still, the stigma is still there.

Judith highlighted how stigma becomes a part of individuals' lived experiences when they are categorized as different in any way. This participant was resigned to the fact that stigma will remain a part of her life and something that she will have to continue

to endure. This realization was also one that Angela had. In her interview, Angela talked about being made fun of as a kid and how it took her until her 30s to build up a thick skin so she could endure the stigma. When asked about how she developed the thick skin she has, Angela explained that it came from enduring stigma and bullying from a young age.

> It's just I've built it [thick skin] up over time, so it's just - it's there. I've been big since I've been maybe seven or eight. So just kind of ... I can't get rid of it (laughs). It's part of me.

Angela also talked about how her previous traumas influenced her endurance for stigmatizing experiences. It is clear through her explanations that endurance is a complex concept that affects marginalized groups of people in many ways.

> It probably makes me feel sad for a couple days but then I like, kind of snap right back. I have always been someone who gets depressed but am able to pull myself out of it, um, especially after everything that I've been, I've been through. But I feel I can pull myself right back up.

Here Angela highlighted the temporality of endurance. She talked about everything that she has been through in life building up and helping her develop a sense of endurance and resiliency that she considers to be unique. Many participants saw their endurance and ability to cope with stigma better than others as an asset that helps them be successful in life. Elizabeth talked about her endurance as something that was innate within her and that helped her strive for success.

> That's how I've grown up, like trying to always be the best in what - in all that I can do, and doing my best work, and not giving up. And like even if it pushes you to your limit, like you've gotta keep going. Um, so yeah, I don't think that's from

anyone else; I think that's just what I feel. But I'm consistently thinking that though. But that helps me to push more than what I thought I might have been able to do.

Elizabeth highlighted how valuable it can be for her to be pushed to her limit and be able to keep moving forward. Throughout her interviews, Elizabeth placed value in a strong work ethic and the ability to distance herself from discomfort, whether physical or mental. It is clear through this example and others throughout her interviews that she ascribed to many stoic ideals and behaviours.

Some participants spoke about the unique intersection between emotional/mental and physical endurance. This presented itself as people who put off seeking healthcare because they were able to endure pain better than others or rationalize their pain/discomfort to themselves in order to not seek care. Miriam talked about not seeking care from the emergency department at the hospital due to past stigmatizing experiences.

I'd rather suffer it out. I'd rather call my doctor and go see my doctor than I would go to the [emergency room].

This participant was willing to endure discomfort for longer in order to seek less stigmatizing care. Luckily, she was able to seek care from her own doctor, but some participants experienced more barriers to accessing healthcare and endured pain/discomfort for longer periods of time.

Endurance can also relate to physical capability. Ryan talked about his physical endurance as a higher-weight individual.

But, as for going, like, outside and hiking and stuff, I found that to be quite difficult when I was bigger. […] I found keeping up with them hiking, I always

felt like I was holding them back, or something like that. Like, I would push myself to keep going, but it was very tiring.

Here, Ryan talked about something that was very common amongst many participants. He highlighted the need to purposefully increase his endurance and push his limits to keep up with his thinner friends. Ryan internalized the stigma around being unfit as a higher-weight individual and forced himself to endure discomfort to avoid being seen as unable to keep up. This comparison to others and their physical capability was common within the endurance theme. Angela also prided herself on being able to endure more physical activity than younger and thinner individuals.

My mom's friend always says, "[Angela] has more energy than half the teenagers around". And it's crazy, cause I do, like I'll go swimming for hours with kids where the teenagers are like, "I can't do it anymore. I have to go check my Facebook." (laughs)

It seems that this pride in physical ability was a way for Angela to avoid stigma. Inferring from this quote, it seemed that she could challenge weight stigma that comes in forms of judgement of physical ability by proving that she was still as physically capable of younger, thinner individuals. For other participants, endurance of both stigma and physical ability came out of necessity due to their low-income status. Avery talked about the lack of accessible transit or affordable transportation and how that forced her to build up physical endurance in order to work.

This whole summer, I didn't have a car. So, I biked to work every day because I had to. Um, it was great 'cause it was exercise, but it took me 20 to 22 minutes there and, like, 27 minutes back 'cause there were more uphills going home than

there were going to the gym. Um, which meant that I was stuck, exhausted by the end of every day for the gym. Um, I had to dish out a whole bunch of money for my car and I had to make it work that way. So, like, any of the saving up that I could've done in the last few months all got dumped into a vehicle so that I could travel.

This participant's income over the summer forced her to have to bike and build up physical endurance before she could invest in a car to resist burn out from work. While this may seem tangential, it importantly highlights how many low-income individuals are forced to build up physical endurance to cope with stigmatizing systemic barriers. Without consistent income to spend on vehicles or accessible public transit, low-income individuals often involuntarily build up physical endurance. For Avery and other participants without mobility issues, biking or walking to work or other essential errands was a possibility. However, it is important to not let this solution detract from the importance of developing accessible public transit, as many more participants are physically unable to cope with structural barriers in this way.

In this study, endurance was made up of three distinct but intertwined components: physical, emotional, and mental endurance. A lot of participants felt pride in building up each kind of endurance and overcoming pain, discomfort, and stigma. This sense of pride will be further explored in its own theme, but it is clear that these stoic behaviours and ideals are acutely linked to each other.

Internalization

Internalization as a theme is not one that comes directly from the PAQ-R tool as the others do. However, the concept of internalization is very prominent in research about weight stigma. Mensinger et al. (2018) explain the differences in experienced versus internalized stigma. Mensinger et al. (2018) describe internalized stigma as potentially "even more insidious than experienced weight stigma," (p. 140). Experienced stigma refers to instances where individuals are treated negatively due to their weight. Comparatively, internalized stigma is "self-directed, personalized, and afflicted towards oneself," (Mensinger et al., 2018, p. 140). Durso and Latner (2012) tested levels of self-stigmatization among higher weight individuals and found that they interpellated fatphobic discourses and often believed in social stereotypes surrounding fatness and developed a negative self-evaluation and self-image because of that interpellation. The distinction that Durso and Latner (2012) make between encountering general anti-fat attitudes present in society compared to internalized weight bias among higher-weight individuals is important as it shows that there are higher levels of depression, anxiety, body image concerns, disturbed eating patterns, etc. among those who have internalized weight stigma.

For the purposes of this study and the discussion of this theme, internalization refers to the process by which participants incorporate weight stigma, income stigma, and neoliberal health messaging and ideals into their own worldview and is derived from Durso and Latner's (2012) conceptualization of internalized weight bias. This theme will also discuss how the process of unconsciously absorbing these healthist discourses lead to self-stigmatizing and stoic behaviours. Healthism, as described by Crawford (1980), is

the "preoccupation with personal health as a primary […] focus for the definition and achievement of well-being; a goal which is to be attained primarily through the modification of lifestyles, with or without therapeutic help," (p. 368). Healthist discourses assert that wellbeing is a matter of personal choice and responsibility solely, regardless of if there is an external cause for disease or poor wellbeing (Crawford, 1980). This leads to constructed solutions that remain within the realm of personal choice and behaviour changes, which is evidence in the dominant "obesity" discourses, which see weight mainly as a matter of individual responsibility to fix through diet and exercise. However, personal health choices become complicated by socioeconomic status, a lower income often hinders the ability to attain healthful behaviours (Godley & McLaren, 2010). Healthist discourses that espouse personal responsibility as a means of attaining wellness has both classist and fatphobic undertones.

This theme emerged inductively from the data and is important in understanding the development of a stoic ideology. Internalization might be an explanation for how participants developed particular stoic behaviours in their healthcare experiences and everyday life as a response to the stigma they face. The theme is described as taking the stigmatization personally and feeling negatively about it in terms of self-confidence and emotional wellbeing. For some participants this led to behaviours including making excuses for stigma/stigmatizing experiences and feeling personally responsible for their health outcomes. To better understand how internalization plays out amongst the participants, I will talk about the interpellation of fatphobia and weight/exercise ideals, the assumption of personal responsibility and power dynamics, and how these kinds of internalization are linked to each other. I will also discuss how the internalization of

stigma and neoliberal discourses intersect to instill a sense of burden within the participants.

Most participants brought up the interpellation of fatphobic discourses within their interviews. For some participants, the internalization was covert and may have been unconscious, while other participants were highly aware that they have been socialized to think in fatphobic ways. The uptake of fatphobic discourses was complex as some participants were aware of how "obesity" discourses can be damaging but seemed unaware they were reproducing fatphobic discourses in the way they spoke about their experiences and potential "solutions". Jordan adopted the most radical beliefs. They openly talked about their experiences with fat activism, body neutrality, and the issues of fatphobia in society. Here, Jordan talked about pervasive fatphobic stereotypes.

> The general consensus is more that like fat people are a joke. Fat people are like lower class, like fat people are always... Like, I find people kind of associate fat people with like the worst of everything. Like they associate us with gluttony and richness, but they also associate us with being poor and dirty. And like there's just so many different like nuances of it. That I find it's a very, like everyone has a very complicated relationship with it and I've never met a single person who hasn't been affected by how ingrained it is in our society.

Jordan talked about how they had never met someone who has not been affected by how fatness is talked about in our society. This is especially true for higher-weight, low-income individuals who are multiply marginalized. Fat people are often seen as lower-class individuals due to pervasive, unchallenged, and classist beliefs that fat people are ignorant and require more punitive interventions to address "obesity" (Kirkland,

2011). This is important to remember going forward in the discussion about internalization. However, most participants were not this forthcoming. Instead, they appeared to express possibly unconscious biases through discussion during the interviews. For Elizabeth, this bias was relatively overt.

> I mean, I wouldn't mind being of a lower weight. That would be nice. I would have a lot more positive body image, I guess. But, um, yeah. It's, it's just kind of personal preference stuff.

While Elizabeth explicitly talked about wanting to be at a lower weight, she justified this desire by saying it was a personal preference and would help her have a more positive body image. This suggests an uptake of fatphobic discourses that caused Elizabeth to have a worse self-image and desire a thinner body. Instead of connecting her desire for a thinner body to the thin ideal that fatphobic society perpetuates, Elizabeth explained that it was out of personal preference. This is the narrative that was common amongst most of the participants who restate fatphobic discourses. It was especially explicit for Ryan who saw weight as something that should be lost. When asked to talk about his most positive healthcare experiences, Ryan could not think of anything positive to say about healthcare.

> I wouldn't say there's anything positive because health care is about, you know, taking care of yourself, being in shape. Usually, when I think of health care. It's just keeping yourself a healthy weight is what most health professionals would encourage or, uh, weight loss.

Ryan saw weight loss as an important behaviour that healthcare professionals should prescribe and encourage for their fat patients. He appeared to have interpellated

the dominant, uncritical, often alarmist views on fatness that sees the "obesity epidemic" as a health crisis that has developed from the rise in unhealthy foods and sedentary lifestyles (Gard, 2011). Most participants held these views in some way or another; however, his were some of the more explicit examples of this discourse. In other parts of his interview, he talked about incentivizing exercise and placing health warnings on junk food to curb the "obesity epidemic".

Trevor also talked about ideal exercise and diet norms. It is clear that he was reproducing some of the dominant "obesity epidemic" beliefs that Ryan also shares. The way that Trevor talked about weight- and food-related behaviours as things that should be punished highlights his uptake of fatphobic values from society.

> When I think of really heavy people, the knee-jerk stereotypes in my mind are, oh, they're lazy or they just sit around too much, or they just eat too much. They gotta not eat sweets all the time. Now, here's the ironic thing, I do all those things to extreme levels. Uh, like, if there's anyone who, who should be negatively judged for doing the things that I just listed off it should be me. Like, if I was in court somewhere and the judge had all the accurate facts about how I've lived a large part of my life, I would be found guilty and deserving of punishment for all the things that I just listed off that so-called fat people usually get judged for.

While Trevor understood the damaging stereotypes surrounding higher weight individuals, he still upheld the idea that diet and exercise norms that do not match cultural ideals should be punished, proving that views on diet, exercise, and weight are very nuanced and sometimes contradictory. Avery also talked about the dominant weight and exercise assumptions. While this research does not incorporate a gendered analysis, it is

interesting to note how some participants talked about weight and gender. In this instance, Avery talked about how she interpellated personal weight ideals as a woman that she did not apply to her partners who were men and how those ideals changed based on whether her partner is also a woman or if she is with a man.

> Even though I've gone down about 30 to 35 pounds, and I weight-lift, so I know that muscle weighs more than fat does, but when you step on the scale, like, every two weeks, and it hasn't moved even though your pants might feel looser, you see the number, and so we start to associate that number. That and, like, myself as a woman. Um, when I was in relationships, um, with guys, they would be, y'know, they're allowed to have a little bit of chub, or they can be substantially bigger, but then, um, if I ... uh, the relationships that I've had with girls, and the fact that both of us felt like we needed to watch what we were eating and constantly go to the gym, and always be active. Like, we couldn't really schlump.

This way of understanding weight-based ideals through a gendered lens was present amongst other participants as well. Unfortunately, the sample was not very diverse in terms of gender and therefore a comparison between genders would not be possible. Penelope also talked about how interpellated thin ideals led her to behavioural changes, which can be linked to stoic behaviours specifically.

> I went to [the beach] last year. And I was so like afraid that someone was going to say something. Because my bathing suit wasn't revealing, but it was like, it was a nice one piece. And I thought it was nice and so, I was so afraid that people were going to say something, so I covered up. And I was, it was hot. (laughs) And the girls were having fun in their nice, cute bathing suits. And I'm like laying here,

> I'm like I'm trying to enjoy myself and ... and I was like worried that people were going to say something. I know, nobody ended up saying something. But you never know.

Penelope highlighted how prevailing weight ideals and fatphobic body standards caused her to change her behaviour to control others' perceptions of her and her body. Penelope brought up how she felt about her body in her bathing suit multiple times throughout her interviews. She mentioned that she tells herself that she "looks like a sausage" in her bathing suit even though no one has ever told her this. She openly talked about lacking the confidence she wished she had when she is wearing bathing suits. This sentiment was extremely common amongst the participants, specifically when talking about the beach or when wearing a bathing suit. Many participants used a bathing suit specifically to talk about their bodily discomfort and often explained behaviour changes they would make to feel less vulnerable to stigma. Angela talked about her experience with covering up when swimming to avoid excessive stigma.

> I won't wear a bikini, but I will go out in my bathing suit and go out for a swim. That doesn't bug me. A couple of years ago, it did. I'd wear, like, um, capris and, like, a long-sleeved shirt in the pool.

In this situation, Angela talked about how she was able to overcome that internalization of stigmatizing discourses to feel more comfortable in a bathing suit while swimming. Instead of wearing capris and a long-sleeved shirt, Angela explained that she felt more comfortable in a bathing suit after turning 30 and developing a "tough skin" against stigma or stigmatizing remarks made by others. It was unclear whether Angela explicitly feels better about her body, or whether she just cares less about others'

perceptions of her body, something that she talked about multiple times throughout her interviews. It seems that these two things go hand in hand for Angela; from the data, I can speculate that through caring less about others' perceptions of her body, she has learned to accept and feel better about herself over time.

The way that these participants talked about weight and its causes made it clear that their understanding of weight comes from a stigmatizing perspective. Because of this, there was a pattern of participants being stigmatized both by others and by themselves due to an internal dialogue of fatphobic discourses. By understanding internalization, we can start to better understand the motivation to make behavioural changes to avoid stigma. It seemed that these participants were attempting to avoid stigma and therefore any negative emotions or self-perceptions due to stigma, but the uptake of fatphobia and alarmist discourse stopped them from being able to avoid stigma. This led to self-stigmatization, which can be understood as a manifestation of neoliberal health messaging and conceptualizations of fatness. This makes sense considering the neoliberal ideology that is dominant in healthcare messaging. The so-called "good citizen" is expected to take personal responsibility for their health behaviours and therefore stigmatize themselves under the dominant point of view (LeBesco, 2011). The uptake of neoliberal health messaging and ideals was pervasive in the data. There was an overwhelming pattern the participants feeling a personal responsibility for their fatness and health outcomes, which was likely caused by the interpellation of neoliberal health ideologies in which "the fat body is reframed as a drain on health care because fat people make bad personal consumption choices," (LeBesco, 2011, p. 155). Ryan highlighted the idea that fat bodies are a drain on the system and that they need to control their bodies on

an individual level rather than change society to be more accessible to people in different bodies.

> I find one thing people are doing is making bigger chairs, and I feel like that's unnecessary, almost. In a way. Like, I understand where they're going with it, but that's not fixing the problem, that's just saying here's a bigger chair for the problem. Like, it doesn't address it, it doesn't point it out, it doesn't do anything other than say, you're welcome. […] And sure, it makes them feel better in the moment, but okay, now what? Like the bigger people feel better because they can sit better. Great. That's - that's it. That stops there. There's no further, kind of investment and that doesn't pay back ever. It's just - it's the bandaid. You get no payback for fixing it. Uh, I, uh feel like investments and stuff that will pay back in the future, that's where we should be headed, aiming.

Ryan highlighted how focusing on cost reduction in healthcare continues to push capitalist ideals within the system. According to McGregor (2001), socially prominent economic neoliberal ideals are also pervasive in healthcare policy. Understanding healthcare through an economic lens, as Ryan does in this quote, pushes for a supply and demand framework for healthcare resources. This also forces profit to be prioritized even in healthcare situations (McGregor, 2001). This leads to major discrepancies in care especially when fat people's health problems are dismissed as problems of weight. In the most recent summary of clinical practice guidelines endorsed by Obesity Canada, fat healthcare is deemed as a major health concern causing a significant increase in healthcare costs (Wharton et al., 2020). Through understanding neoliberalism in healthcare alongside the dominant understandings of "obesity" which positions fatness as

a strain on healthcare resources, it is clear to see how healthcare professionals may opt to place blame on the individual rather than providing non-stigmatizing healthcare.

These values can cause major power differentials in healthcare experiences. Coupled with the fact that doctors specifically already hold an abundance of socially legitimated power (Low, 2016), some participants appeared to adopt the view that they know very little about their own body and that the doctors are the experts. It is clear how this can cause participants to excuse stigmatizing behaviours from doctors who are seen as "knowing best" for their patients, even though this may not always be the case. Again, this led to stoic behaviours among participants who accepted that it is their responsibility to change behaviours rather than the healthcare professionals. Elouise exemplified this during her interview when she talked about her doctor shutting down any collaborative healthcare dialogue in her appointments.

> I think he likes to be in, [participant's doctor] likes to be the boss. My opinion is always less than his opinion and therefore I should do whatever he says 'cause he's the boss. (laughs) "Did you have a medical degree?" No. I don't have a medical degree. That's what I hear when I try to argue with him with stuff. "When did you go to medical school?" Well, you kind of got me there so, yeah.

Elouise talked later in the interview about being dismissed since the doctor liked to be "the boss" during their healthcare interactions. She also talked about placing the burden of her health outcomes on herself because of the way her doctor has placed blame on her. Elouise explained that she avoided bringing up health issues with her doctor because he is dismissive, which can be seen as a form of stoicism and stigma management. Jordan also talked about their experiences with personal responsibility in

healthcare.

> I think they discredit us a lot and blame us for our own problems a lot. And say that we're at fault and if we would just lose weight then all of these things would magically be cured even if there's things that genuinely have no correlation with weight and things that haven't been researched well enough to prove that they have a correlation with weight. And it's just such a like knee jerk reaction for people that I like stopped going to doctors for like six years of my life.

Jordan highlighted here how dismissive and fatphobic healthcare can lead to avoidant and stoic behaviours. Rather than see a stigmatizing doctor, Jordan avoided healthcare for six years of their life, regardless of the pain they experienced. The personal responsibilization of fatness and health is pervasive and problematic. As Jordan identified, there are few direct causative links between most health risks and fatness. Many common-sense assumptions exist about fatness, which insinuate that fatness causes diseases like ischaemic heart disease or non-insulin dependent diabetes mellitus (Gard & Wright, 2005). However, it is scientifically illogical to assume that fatness acts as a cause for these diseases when the direction of the relationship between fatness and many diseases is unknown. In reality, fatness is often symptomatic of diseases like heart disease and diabetes (Gard & Wright, 2005). Early moral understandings of the "obesity" epidemic lacked in depth knowledge of health risks and human agency (Gard, 2016). These moral underpinnings of "obesity" persist and cloud doctors' understandings of fatness. Healthcare professionals who do not understand this complexity may continue to stigmatize their patients and provide insufficient care. While there have been critiques made from biomedical "obesity" scholars that using the BMI is reductive and that moral

understandings of "obesity" are biasing future weight-related research (Casazza et al., 2013; Hebert et al., 2013), many scholars still assume that fatness is something that should be treated and avoided through medical intervention or lifestyle and behavioural changes. According to Pausé (2014), "there is a mountain of anecdotal evidence that many fat people have gone decades without appropriate diagnoses due to provider bias," (p. 138). Many healthcare professionals forgo diagnostic testing and rely instead on body size judgements to diagnose unrelated health problems (Pausé, 2014). Trevor also talked about the dismissive care that doctors provide to higher-weight patients. However, he justified the lack of proper healthcare by comparing weight problems to addiction and other health risks that are presumed to be self-imposed.

> I have a history of alcohol abuse and dependence, and also drug abuse and dependence, cannabis stuff and their derivatives and also tobacco. If I'm at the doctor talking about breathing problems, or lack of energy, or, you know, I have a cold four times a year, or, you know, I just, like, I'm half dead at the top of the stairs, uh, I mean, the doctor is going to make a lotta quick assessments and say, "Hey, man, like, you're an alcoholic, you smoke, you smoke dope all the time, what do you want me to do? Like, there are certain things that you need to take care of that you're not taking care of." […] And so, extrapolating from that, it's possible that when doctors are dealing with overweight people, like, really overweight people, you know, like a . . . like a five-foot person who's 250 pounds. It's like, oh, my knees are killing me, my back is killing me you know, I'm in first stage diabetes or whatever, you know, when your diet is so horrendous, you're, you're basically inviting diabetes. Like, extrapolating from

this addiction of my own, it's possible that the doctor will be like, "Well, hey, you know, like, I mean, like, there are things going on in your life. They're within your realm of control or, or at least they should be, or at least you should try to investigate the fact that they might be within, within your realm of responsibility to do something about."

Trevor endorsed the idea that health and weight are matters of personal responsibility. Additionally, Trevor showed here how weight is misunderstood by both lay people and health professionals. Fatness is often pathologized in a way that reframes it as an addiction, typically to food (Murray, 2008). Murray (2008) talked about how shame led to changes in eating behaviours amongst fat women, which are often synonymous with behaviours related to addiction. When the eating habits of higher-weight individuals are judged publicly, many fat people respond by hiding what they eat. For Murray (2008), "the private fat body that eats is constituted as engaging in addictive behaviours and permitting the fulfilment of excessive desires" (p. 217). When fatness is understood as an addiction, the dominant biomedical and fatphobic discourse around weight is perpetuated and continues to harm fat people. However, Murray (2008) shows that fatness is not a problem of addiction, but the cultural meanings placed on weight and eating act to perpetuate negative stereotypes that fatness is representative of moral failings and character flaws.

For some participants, the uptake of fatphobic discourses, created feelings of personal responsibility and a sense of burden within the participants. Judith talked about how her disability and higher weight status make going out very inaccessible and how that creates a sense of burden within her life.

> It doesn't make you want to go anywhere, makes you depressed, make sure you hate this life, hate this body, you know. So basically, the societal judgements, um, make you basically feel like you don't want to move. […] Make you feel like a burden rather than being an active participant in your community.

Judith talked about how rather than being the active participant in her community like she wanted to be, she was often overcome with a feeling of being a burden to those around her. This often led her to avoid social interactions and staying in her apartment more often than she wanted to, as she talked about throughout both of her interviews. In addition, Judith talked about her low income, meaning that she often relied on public transit for outings. However, due to her weight and disability status, accessible transit was often unavailable when she needed it. To rectify this, Judith unwillingly relied on drives from her small support network. Judith talked about this adding to her sense of burden throughout her interview. Jordan talked about similar feelings of being a burden due to lack of accessibility for people in fat bodies.

> And I think like one good thing is like accepting help from other people, which it took me a long time to like get to that point. Like it was literally just like last week or two weeks ago that I finally got past my anxiety to post on Facebook. Just like not even genuinely like asking one on one, asking someone for help but just putting it out there being like, "Hey, I need to run some errands. If any of my friends that drive would want to give me a lift." And like that took so much to like get past the anxiety of doing that, 'cause I'm so afraid of asking people for help. But I guess just like recognizing that you're not a burden and it's okay to ask for help. […] I think those are like very important things that people need to process

especially when they live in a disabled body, or they live in a fat body, or they live in a low-income household, or they live like somewhere where driving is inaccessible. Like it's just like really important to recognize that you're not a burden and you deserve help and you're allowed to ask for it.

Much like Judith, Jordan talked throughout their interviews about feeling like a burden to those around them and changing their behaviour to avoid those negative feelings. Instead of placing themself in a situation where they would feel like a burden, they avoided going out in public and often stayed home in their apartment more often than they would ideally like to. Jordan actively controlled their situation to avoid negative emotions and stigmatizing experiences and therefore adopted certain stoic ideals and behaviours.

Labelling

The theme labelling comes from the stoic-fortitude subscale in the PAQ-R. Stoic-fortitude is understood as having courage in the face of pain (Yong et al., 2003). Labelling specifically comes from the ideals of being able to go on as if nothing happened in the face of pain (stigma) and that there is no good complaining about painful (stigmatizing) experiences or pain (stigma) in general (Yong et al., 2003). Within the data, labelling came to be understood as how the participant communicates about and chooses to label stigmatizing experiences. It also captured whether the participant finds the experience worth talking about or if they are more likely to label talking about stigmatizing experiences as complaining.

Some participants were likely to label their experiences as stigmatizing with little hesitation, while others were unsure as to whether their experiences were stigmatizing until probing questions were asked. For example, Penelope explained that she was more reflective of the mistreatment she felt during healthcare experiences when asked specifically about them. It seemed that many participants shared this sentiment; the uptake of fatphobic discourses may hinder the ability for participants to perceive experiences as stigmatizing. When asked about their positive and negative experiences in healthcare and how they relate to their weight and income status, some participants were more likely to explicitly view their experiences as stigmatizing and label them as such. Others did not label their negative experiences as stigmatizing even when asked directly about them. For those who were hesitant or did not describe their experiences as stigmatizing, participants often appeared to justify structural or systemic issues. Instead, participants often assumed personal blame or responsibility, insinuating that any negative experiences that they have had are due to who they are as a person and not the negative biases that are instilled in others. As with other themes, this was likely a reflection of prolific neoliberal discourse and health messaging regarding fatphobic weight, exercise, and diet ideals.

Participants seemed particularly unlikely to be critical of their family doctors or healthcare professionals in general compared to members of the lay public. Elouise exemplified this trend when talking about her doctor.

> Um, unless I didn't have the, the ability to buy fruits or vegetables and stuff, um, I don't think he would listen to that as an excuse or a reason or whatever. But, um,

but I, I don't think I'm treated any differently because I'm on disability or anything.

In the quote above Elouise did not consider her doctor stigmatizing when her doctor would not accept income barriers as an excuse for not being able to afford nutritious food. Elouise's statement suggests that her doctor saw health as something that is universally attainable and meant to be achieved on a personal level regardless of systemic barriers. Elouise appeared to excuse this behaviour, likely because it was a more covert type of stigma and matches with neoliberal, classist health messaging. This aligns with Farrell et al.'s (2016) understanding of low-income stigma in health messaging. For Farrell et al. (2016), high-income individuals often ignore structural barriers in favour of presumed ignorance in low-income individuals.

Not labelling doctor's behaviours as stigmatizing is prevalent among other participants as well. Specifically, Elizabeth, Ryan, and Trevor all stated that they have not had stigmatizing experiences with their doctors, yet they all disclosed instances that could be construed as stigma, including instances of mistreatment due to presumed addiction, a focus on weight loss instead of other solutions to health problems, and dismissal of non-weight related problems as problems of weight. Reproduction of the idea that "doctors know best" and they do not cause harm for their patients was very evident in the way that most participants talked about their healthcare experiences. However, participants similarly made allowances for structural barriers and stigmatization outside of healthcare as well. As low-income individuals, many of the participants relied on public transit in their daily lives. Most participants identified certain

ways that transit could be improved, but very few of them were eager to speak poorly about the transit system in general, especially Trevor.

> It would be nice if they had Sunday service. But other than that, I find them more than adequate. I don't have any complaints. I mean, the only thing that comes to mind is possibly cycle the buses maybe faster. Like, if I missed the one that's going out to Brookside, then I can't get on the next one for an hour. So, you have to be careful. Don't miss that bus because it's a big price to pay if you miss it. You get into the bigger cities and the buses roll around every 15 minutes. Or five minutes. Or half hour at the latest. But in Fredericton here it's an hour. And if you're going out Silverwood or Lincoln there might only be four trips a day there.

The lack of adequate funding for public transit in New Brunswick disproportionately affects the low-income population. People who cannot afford a car or are not able to drive must navigate the transit system that has inadequate scheduling. Foth et al. (2013) studied the accessibility of transit in Toronto for socially disadvantaged groups and found that lack of access to transit was a significant barrier to employment and mobility. Equitable transit benefits include "high accessibility to opportunities, short travel time, long service hours, short wait and transfer times, and routes that reach desired opportunities," (Foth et al., 2013, p. 2). These benefits are especially important for individuals who do not own a car, many of whom are low-income individuals (Foth et al., 2013). As Trevor talked about, if you miss a bus, the next one does not come for hours, leaving low-income individuals underserved and unable to continue with their days until the next bus comes.

However, as seen in this quote and evidenced in the data, many individuals were unwilling to be hyper-critical of the transit system in general. Trevor talked about having "no complaints" specifically, showcasing his stoic-fortitude behaviours of finding no good in complaining. While this was not necessarily an overtly stigmatizing event, it speaks to the problem of structural barriers and the excuses that are made for them. Trevor was not alone in these sentiments, with some participants going as far as saying that it is their own personality or behavioural traits that make transit inadequate, rather than the transit system itself. Some participants talked about not being the kind of person who likes to wait around for the bus, blaming their impatience for the inaccessibility rather than the delays in transit scheduling. For other participants, they blamed their work or social schedule for not being able to use transit instead of the need for the transit system to operate for longer into the evenings to accommodate theirs and others' schedules. Ryan even placed blame on himself for not engaging in alternative transit methods, like biking, instead of blaming the inaccessibility of transit. The way that these participants related to systemic barriers and excused them and instead, placed blame on themselves highlighted the interpellation of neoliberal health ideals such as individualism and free market capitalism (McGregor, 2001).

While some participants did label interactions with lay people as stigmatizing, the idea that stigmatizing experiences were only negative because of the participant's individual personality was still pervasive. This was especially true for participants while shopping and in places that are not size accessible.

> There haven't been too many places where it's been a noticeable thing just shopping. Um, so thrift stores having items that are bigger, that makes it easier.

> But even sometimes there are instances where I still don't find anything there too. […] I haven't actually been ... I don't know how you say like looked down on for that reason, I guess.

Elizabeth talked here about her negative experiences while looking for clothing. Elizabeth recognized that shopping can be a personally negative experience, but still did not see blatant and systemic size exclusion as fatphobic and stigmatizing. She did not feel "looked down on" for being a higher weight in clothing stores and therefore did not label her experiences as stigmatizing. Understanding how participants conceptualized stigma as something overt and explicit can help researchers understand why certain stoic behaviours are developed, like unwillingness to label experiences as stigmatizing. Using Link and Phelan's (2001) conceptualization of stigma, cultural stereotypes that are pervasive in society are perceived at a very young age and become lay theory. How people understand and label stigma is a result of how much they have interpellated those stereotypes (Link & Phelan, 2001). In terms of stoic behaviour development, in this analysis I infer that the intensity of stoicism present and willingness to label experiences as stigmatizing stems from how ingrained those stereotypes are in each individual's world view. Due to this, how participants labelled negative experiences varied widely. Penelope talked in her interview about feeling uncomfortable shopping in stores that did not cater to her body size due to perceived biases amongst the retail staff and lack of clothing in her size. Penelope also brought up how fatphobia exists explicitly in dating culture, but again placed blame on herself for being self-conscious and exaggerating negative perceptions.

> Like, even like dating and stuff like, I've been this size since middle school. (laughs) Brutal. So, I haven't gotten, like, grown that much but ... dating is rough. Especially when you're like wow, if I was just a little bit more skinnier than they would accept me more.

Penelope highlighted the pervasive beauty standards that start at a young age and are extremely fatphobic. Penelope went on to say that she has changed the way she thinks about herself and did not wish she was skinnier as much as she used to, but she still expressed self-blame that reflects problematic cultural discourses. Instead of critiquing dominant beauty standards, Penelope, like many others, lived her whole life wishing to be skinnier to be desirable. This showed her seeming hesitancy to label these individual and internalized stigmatizing experiences as such and can be read as a stoic behaviour.

In other instances, some participants were willing to describe stigmatizing experiences as negative, but still often made excuses for why this was the case. Some participants only described experiences as stigmatizing when the stigma was overt and explicit. Even among people who labelled experiences as *negative*, there was still hesitance to label an experience stigmatizing. Angela described her healthcare experiences as "fine", but also described being covertly stigmatized through looks and negative comments.

> Like, I've never had someone refuse to provide healthcare because I'm bigger or stuff like that. But you do get looked at differently. You do, you know, some people say things that they shouldn't say and stuff like that. You know, feelings get hurt. But other than that, it's fine.

While this was closer to labeling experiences as stigmatizing, there was still a hesitation from Angela to be fully critical of the healthcare system and her experiences within it. Understanding this nuance is important and goes to show that participants might adopt stoic behaviours in some situations, but it is not always straightforward. Ryan was more willing to be critical of the healthcare system and professionals but was still tentative about labelling certain experiences as fatphobic or stigmatizing.

> When you're constantly saying all your problems are your weight, it might not address the issue properly. When they say, "Yeah, you're overweight. That's the problem," that's a blanket statement. Like, "Hey, you need to fix this one particular issue and then here's how you do it." It's just, "You're overweight. Lose weight." And I mean, because the healthcare system is just so, gets people through, I guess a revolving door. You step on in, "You're overweight," get out. I mean, it's easy so I can see why.

Ryan talked about how doctors used blanket statements like "you're overweight" to dismiss other health problems that were not weight related. This is an important and critical part of what fat liberationists and activists are trying to address in the healthcare system, but Ryan saw this as an easy diagnosis for doctors who do not have time to properly assess patients. He did not view this instance as specifically fatphobic; therefore, biased behaviours were excused, and time was recognized as the main issue. This may have been a means through which Ryan could potentially distance himself from a stigmatizing healthcare experience.

Trevor vacillated between describing how doctors may hold biased views of higher-weight people as broader members of society but also believed doctors may hold

more nuanced views of a simplistic "energy imbalance model" of "obesity" etiology. This contradiction among the views of healthcare professionals was captured in a study that assessed implicit weight bias within a group of healthcare professionals that attended the Annual Meeting of the North American Association for the Study of Obesity (Schwartz et al., 2003). The researchers found that healthcare professionals, regardless of their understanding that weight is influenced by external factors, still held ant-fat beliefs and accepted stereotypes that higher weight individuals are lazy, stupid, and worthless (Schwartz, 2003). These implicit biases were found in several studies completed regarding weight stigma and its effects, outlined by Alberga et al. (2019). Trevor also recognized the nuanced views of healthcare providers during his interview.

> I'm thinking that just given that [doctors are] human, there would be a lot of those negative stereotypical thoughts that they would have for overweight people. You know, it's like, man, this person, why don't you just stop eating all that stuff? Why don't you just stop being a couch potato? And just kind of look down on them for that. I'm thinking that there would be some amount of that thinking, but, then again, these people are doctors and there's probably, well, there's undoubtedly a whole realm of understanding that they have relative to knowing about gland abnormalities, and mental illnesses, and different things like that that contribute to all this weight gain rather than just the standard, layman's knee-jerk reactions. So that, I think they would have a bit of both.

Trevor talked here about the difference between lay and professional understandings of weight. He was able to discern stigmatizing attitudes that many people have, regardless of profession, about higher-weight individuals. However, there was still

a willingness to give doctors the benefit of the doubt because of their education and understanding of other health conditions. The idea that medical training is preventative of weight bias and stigma was pervasive among the participants. Health professionals were often held as "knowing best" for their patients, an attitude that was apparent among many of the participants. This may have been a barrier to holding professionals accountable for their internal biases and may be why some people were hesitant about labelling people and experiences as stigmatizing or problematic.

While there has been a shift towards patient-centered and mutually participative healthcare, the doctor-patient relationship historically has been marked with power which placed the patients as passive and unknowing, especially for lower class or low-income patients (Kaba & Sooriakumaran, 2007). According to Szasz & Hollender (1956), the doctor-patient model of guidance-cooperation, which is still practiced today, the doctor is placed in a position of power and expects the patient to obey without question (as cited by Kaba & Sooriakumaran, 2007). Elevating healthcare professionals above their patients, functions to enact a power dynamic in which the healthcare professionals can stigmatize patients who have less power (Link & Phelan, 2001). It can be inferred that this might have caused hesitancy from patients to label their experiences as stigmatizing, as they would have interpellated long-standing stereotypes that persist in society.

The participants who did label experiences as stigmatizing and described engaging in self-advocacy in those stigmatizing experiences were more open to talking about social power structures and inequalities in their interviews. For many participants, talking or thinking about social inequalities was not something they did in their daily

lives. Penelope talked about how she only started being more aware of covert stigma and oppression when being asked about it in the interview.

> I'm like, "Oh, are they looking at me because I'm big? Or are they looking at me because I'm tall? Or are they looking at me because of my race?" So, I'm like, well. One, it's always one of the three then it's annoying. I mean, it's so annoying like, talking about this stuff, I'm like holy cow, like, I never realized how much those things kind of influence. But they do. I don't think about it often but, this just made me be think about it much more.

Penelope is multiply marginalized as a fat, black woman, which made her acutely aware of her presentation to others. However, it wasn't until talking about her experiences with covert biases that she was able to consciously realize how much those stereotypes affect her. These data indicate how important education around fatphobia is important in professional, educational, and personal spheres to potentially combat this stigma. In contrast to other participants, Jordan explicitly labelled their experiences in healthcare and everyday life as stigmatizing. Jordan actively called themself a fat activist during their interview and talked about the power of education and advocacy as being pivotal in their body neutrality journey. They labelled the experiences they had as stigmatizing without hesitation.

> I'm genuinely really passionate about like fat positivity and ending weight stigma and how people think that it's just about like body positivity and it's become very mainstream and watered down and about these like cis, thin, white women being like, "I'm positive because when I sit down, I have a roll on my stomach." And that's like fine and dandy and I want people who have that body to celebrate their

> own bodies, but weight stigma and fat phobia comes down to it genuinely affects people's lives and it genuinely like, the lack of healthcare that we receive it kills people.

In Jordan's interview, they talked about their personal experiences with weight stigma and how that affected their life. However, not all participants were as vocal and active in the fat positivity community. Judith never identified herself as a fat activist in the same way that Jordan did, but through her experiences being chronically ill and at a higher weight her whole life she developed a similar critical stance. Judith demonstrated a critical edge when it comes to weight stigma and common misconceptions about weight, especially living with a chronic illness.

> You know, and when they see you as a fat person, it's like, oh, that person doesn't take care of themself. That person doesn't eat healthy. You know, they don't realize like, okay, you give me a medication. And it says the first like five side effects are usually the worst side effects. Right. The second side effect is weight gain. So how does the doctor expect the patient who's immobile to not gain weight on that medication and then still continue with the fat stigma.

Judith labelled certain doctors she had encountered and their behaviours as stigmatizing during her interview. Many doctors that Judith saw held very stigmatizing beliefs about weight and how it affected her hormone abnormalities. This caused one of her specialists to dismiss her hormone issues and blame her condition on weight, effectively stalling her diagnosis and treatment until she was able to advocate to see other specialists. She also spoke throughout her interviews about the importance of being self-educated when it comes to her own health problems. This highlighted once again the

importance of accessible education for lay people, as mentioned multiple times throughout the participants' interviews. Studies show that education increases patient engagement and positively impacts patient experiences and outcomes (Gruman et al., 2010). It also aids in the movement to patient-centered care with an importance placed on mutual participation between healthcare professionals and patients (Kaba & Sooriakumaran, 2007).

Judith talked openly about how important her education was in her self-advocacy efforts. Due to Judith's education background, she was able to learn from medical articles and journals in a way that others were unable to. She often used this access to knowledge to help her friends who were not well versed in medical jargon and spoke about how important it is to make medical materials more accessible to lay people. Other participants, like Jordan, echoed the importance of accessible educational material to help individuals engage in self-advocacy. Miriam also talked about the need for education and explained that she has had to educate and diagnose herself on behalf of the doctor.

> I feel like you have to diagnose yourself and tell them what you have. Education to me is number one. And just because you've got a certificate in something, it should never stop there. You should be made to go to school frequently because everything's changing. Every day there's something different that may relate to your profession or situation or, you know. But even when I was crying, hanging on to my side of my neck and jaw, I said, actually I'm going to look in the mirror, see if I see anything. And sure enough, I've seen this white thing all over the gland in my throat. I went back to the doctor. He told me it was a saliva stone. He put me on antibiotics. I was on antibiotics for, like, three weeks. There was no

> difference. It was just getting worse and worse. Went back to him, said, "Oh, you got to go see a specialist." Went to the specialist. He did a biopsy, and it came back I'm full of the lymphoma. That's cancer of the lymph nodes. And with the tests that they did, they said I'd had it for some time. And I said, "I know. I have had it over five years." Five years I took a turn. I said the last two years was bad, but the last eight months was hell on earth. So, I feel that because doctors diagnose you with something, they relate it to whatever you're complaining about, they can relate it to what they diagnosed you with.

Miriam highlighted the importance of doctors continuing to educate themselves with new material to better keep up with their changing patients. She also talked about how doctors will find a way to diagnose patients with what they think the patients have rather than doing tests to find out for sure. For Miriam, this meant that she had to go through a course of antibiotics that did not work because the doctor was unwilling to test her for lymphoma. In a different instance, Avery struggled with this as well but in a scenario that was more specific to her weight.

> Because it shouldn't really matter if I'm suddenly having these problems 'cause I was at that weight for probably about a year. Approximately a year, give or take, if I was just suddenly starting to feel those pains now, it wasn't just my weight. I figured it was due to the accident and I was basically told, "No. Like, maybe you should try losing weight first so that we could make sure that it is." And I'm like, "Yeah, but I'm, not I'm gonna be going through pain whilst trying to lose this weight." And now, this hasn't gone away. I'm still in pain. Not as much, but I've also changed from being a student and having to sit all the time to at least at one

> of my jobs I sit and stand a decent amount. […] So, it hasn't fully gone away. So, I know that it's not the weight that caused it. It's more just it made the doctor's office is not necessarily a safe space for me to be in.

Avery talked about how the doctor she saw dismissed her hip pain as a problem having to do with her weight and not something else. Years later, after losing weight, Avery was still having issues with hip pain, proving that the doctor did not adequately treat her. Avery was also university educated at a liberal arts school, which meant she formally learned how to be critical of social inequities, potentially contributing to her readiness to label her experiences as stigmatizing.

Understanding whether or not an individual labels an experience as stigmatizing is complex. It can depend on if the participant takes up fatphobic discourses or not and whether possibly stigmatizing experiences are overt or covert. There were obviously some stoic behaviours present; however, since the situations vary so much between participants and even between situations for each individual, it cannot be said whether these participants have fully adopted stoic-fortitude behaviours like a reluctance to label something as stigmatizing.

Pride

The theme of pride comes from the stoic-concealment subscale of the PAQ-R. Stoic-concealment is understood as a lack of willingness to disclose pain (stigma) to others (Yong et al., 2003). For pride specifically, it refers to maintaining pride in the face of stigma and is closely connected to keeping a stiff upper lip. For the data analysis, pride was defined as maintaining pride of sense of self during or after stigmatizing experiences.

Pride is distinguished from the theme of stiff upper lip because it refers specifically to a sense of self in the participants. For the participants, this often led to a change in behaviour to protect themselves from internalizing stigma. Importantly for this discussion, pride is not meant to refer to a feeling of honour or boastfulness. Instead, maintaining pride is meant to depict the sociological concept of saving face, meaning to retain respect or avoid humiliation (Merriam-Webster, n.d.). There were certain situations that forced participants to engage in pride maintenance behaviours including perceiving pity from others, trying to avoid embarrassment due to others knowing their personal information, and the ingrained drive to be the best versions of themselves, informed by capitalist, fatphobic, and neoliberal beliefs.

Another important driving factor for prideful behaviour was to avoid shame from others. Shame is an important concept to understand in how it relates to fatness and the dominant "obesity epidemic" narrative. Shame is used differently among various professional and lay groups of people to address the "obesity epidemic". While similar to feelings of guilt, shame is used to describe the internalization of guilt, leading to feeling not good enough or having a personal sense of shortcoming (Thomson et al., 2015).

Lazare (1987) developed a three-point framework to understand how shame is perceived in a clinical setting. For Lazare (1987), shame operates in the interaction of these three factors: (1) shame-inducing event; (2) vulnerability of the subject; and (3) the social context of shame. Shame results in hiding or disappearing to protect from further shameful events (Lazare, 1987). Additionally, Thomson et al. (2015) discuss how shame is "based on the evaluation of 'self' in the form of its real or imagined appearance to the 'other' and the imagined judgement of that appearance (conveyed via facial expressions,

gestures, verbal intonations and explicit criticism) by the other," (p. 34). Understanding shame through the perception of others and their real or perceived judgement coincides with a symbolic interactionist understanding of the self through the lens of the other. Shame can be understood through three categories, one of which is being the concern of offending others through sight or what we can understand as physical appearance (Lazare, 1987). This particular understanding of shame can help highlight the intersection of fatness and shame.

As an example, Warin (2011) unpacks the connections between weight income, shame, and judgement when analyzing award winning chef Jamie Oliver's reality TV show, *Ministry of Food.* Warin (2011) highlights how Jamie Oliver displays the eating habits of low-income citizens of Rotherham, UK, in very personal and judgmental ways. This bred shame amongst the reality TV guests for their eating habits and effectively enforced neoliberal consumption norms and self-governance around diet and weight loss tactics. Displaying the intimate aspects of the lives of higher weight, low-income individuals in the UK, Jamie Oliver shamed the food choices of these individuals on national television as a way to address the "obesity epidemic".

In the present study, one of the most frequently recurring points where pride came up among the participants was when they were facing an interaction or situation that brought on feelings of being pitied or shamed. For Judith, she would not accept people taking pity on her, even when she was unable to do certain tasks.

> And, people, like, rather than have empathy for you they have pity. Right? And no one wants pity. Empathy and sympathy are bad enough, but you know, um, pity is even worse.

Judith talked in her interview about not accepting help from people who pity her as a way of maintaining pride. Ryan also had an interesting experience where he had to confront being pitied by someone whom he would normally pity.

> Lower income is definitely here. Because everyone's on a lower income. Anyone that's begging on the streets […] actually, funny story, some bum, uh, I don't know if that's derogatory. But like, someone begging for money came out. I was walking down the street, just left my apartment, came out. He was like, hey, you got some money? Can I borrow 200 bucks, which I thought was absurd. I'm like, no, bud, I only make that in two weeks. And then he started taking pity on me. Like, the guy asking for money took pity on me.

In the interview, Ryan made it clear that he was in disbelief that he was being pitied by a panhandler who was asking him for money. This shows that being on a low-income can be a reason why pride is asserted when faced with pity from others. Miriam talked about low income being a source of pity as well. She talked about her experience at a food bank with a worker who was shaming the low-income patrons.

> She had the wrong... she had the wrong attitude dealing with, uh, you know, low-income people, um, making them feel like they're second-class citizens. And, um, we all have a life. We all, you know, we're all there for the same reason. We need food.

In order to maintain her sense of pride, the participant seemed to blame the worker for her negative and shameful attitudes. Like shame and pity, embarrassment was a strong challenger to pride among the participants. The data suggested that to maintain pride in the face of embarrassment or to avoid embarrassment all together, many

participants changed their behaviours. Physical appearance was a source of embarrassment for many participants and often triggered prideful behaviours. For Ryan, embarrassment regarding his weight caused him to attempt weight loss strategies to reassert pride around his appearance.

> I kind of have it in my mind that I don't want to be, like, bigger. Since I've been around people that are bigger. I don't want to be like that in a sense. I understand people have preference. But there's a point, where, like you say, when the chair doesn't fit you. I think, that should be the breaking point. You're like, shit. That's not good. And ... I don't know. I feel like I was getting to the point where it was noticeable, like, in my self-image. Like, any time I would look at myself, it was very noticeable that I was bigger. And it was very discouraging and disappointing to see myself that way. Especially when I never have. Like, I used to be a lot smaller.

He talked in the interview about going to the gym and trying to eat better to lose weight since he did not want to be bigger. Ryan talked about his weight negatively affecting his self-image and therefore changing his behaviours to avoid the negative emotions, which aligns with stoic behaviours. Trevor also talked about changing his behaviours and outward appearance to avoid embarrassment and stigma for his income.

> I'm very careful about how I present myself. There's a certain abandon that can happen to drug users and alcoholics and welfare people and mental illness people. There's a certain type of abandon where you know, like your clothes can start to get a little shabby. And you can kinda let your hair start to grow long your personal hygiene kinda falls off. And there's a lot of scruffiness and, that type of

thing. And I really try my best to not let that happen. Like, I want my clothes to look good. I want to shower regularly. I wanna be clean shaven. Like, yes, I am on welfare. And yes, I have mental illness. I'm on meds for it. Yes, I do go manic, and I act crazy every now and then. Currently, I am clean, sober and smoke-free. But I don't seem to wanna advertise all that by kind of dressing shabbily and growing my hair and looking kinda sketchy-looking and that kind of a thing. So, that seems to help a lot. Like, I don't, I don't really notice any treatment. It's like, "Oh, you're just on welfare." Like, "You're so poor." I am very poor, uh, very poor. But I present okay. At least, I try to. I do. I make a, a concerted effort to present okay. […] I wanna kind of dress the part, I guess.

Trevor sought to understand himself through the perspective of others, which aligns with the symbolic interactionist concept of understanding and creating a sense of self (Cooley, 1964; Blumer, 1969). He understood the stereotypes people hold of people living with addiction and mental health problems on a low income; therefore, he changed his behaviours and appearance to maintain pride relating to his sense of self. He appeared mildly boastful throughout his interviews and talked often about "doing alright" in relation to hiding his income and personal struggles. Trevor distanced himself from the low-income stereotypes and therefore could be prideful. Elouise was less worried about being embarrassed due to her appearance, but instead was worried about maintaining pride in how she was perceived by others.

We went to a park. And they have this big mobile cart kind of thing that they bring lawn chairs for tourists or whatever. You just give them your driver's license. And they keep it until you bring the chair back. And I thought ... (laughs)

> I have seen so many fail army, and funny home videos where usually it's like, plastic lawn chairs. One leg buckle, and so, I was paranoid the whole time, I was like, 'cause those lawn chairs are only rated for like, 170, I think. And then I got a big boy chair after that and it was weighted- rated for like, 240. So, even taking a chance sitting in that because (laughs) at the time I weighed 303, now I weight 270. […] So, I won't take the chance.

Elouise talked here about changing behaviours in order to maintain pride in how others perceived her. She talked about the fear of being made fun of through internet videos and TV shows that highlight the "fails" of others, specifically videos where higher-weight individuals break lawn chairs. Instead of facing the possibility of a stigmatizing or embarrassing experience, Elouise bought her own chair and was still very cautious when sitting in it.

Other participants talked about disclosure of personal information as being threatening to their pride or embarrassing. Angela talked about how she felt lucky to not have gone to the hospital with anything embarrassing.

> I've never gone [to the hospital] for anything like embarrassing. The most I've gone there for I think embarrassing would be like...actually when I was in grade 9, I stepped on three spikes and they went through my foot, so that's the only like big thing that I've dealt with. I wouldn't want my aunt knowing little things like that or, you know, my uncle knowing something. Even my sister who works in the hospital, I wouldn't want her knowing that either. So, it'd be embarrassing. So that kinda sucks.

Since Angela lived in a small town and her family worked at the hospital, she was cautious about disclosing stigmatizing details, stating that it would be embarrassing for her sister to know her medical information. Angela's ability to avoid disclosing that information protected her pride and sense of self. Other participants, like Judith, were not as lucky and have had to disclose stigmatizing information in healthcare experiences.

> It's a small city so everybody knows business. You know, people used to see a coffee shop or a bar or a restaurant years ago and know the people who are your intake, right. And you can tell they're uncomfortable. Right. And then you're uncomfortable. Now they know everything about you.

Again, since she lived in a small town, Judith knew how fast information can get around and there was no way to avoid people who work in the hospital as well. She talked about being uncomfortable with healthcare professionals knowing her information since she saw them in her daily life. Again, this threatened her pride and sense of self; however, she was unable to change her behaviours due to medical necessity, which makes a stoic personal ideology complex in its deployment. However, it was clear to see that when she had the ability to control her behaviours outside of healthcare, Judith did so to maintain pride.

> I made a decision when I was young to prove people that I was not my fat, that there was me in here beside the fat, behind the fat. So, whatever a skinny person could do, I could do. And knowing the disease I have now was half the reason I could do it because I have Ehlers-Danlos, so you're very limber, you're very flexible. Right? So, in grade nine and grade 10, I won two competitions by Participaction Canada when they came for our school, people were just like

> dumbfound that I could. It's because I could reach further than anybody else, right. Because I had the flexibility issues. And it was proud, very proud for me to, to win those couple of awards. I did everything, at nighttime I would, at home, I would practice things so I could do them, that other kids could do because they were thin, and I couldn't do them.

For Judith, and many others, the ability to perform at a high level, regardless of weight, was a major source of pride. Judith talked later in her interview about the need to succeed being instilled in her from a very young age. According to Rich and Evans (2008), "an individual's character, value and their sense of embodied self comes to be judged essentially in terms of 'weight', size or shape," (p. 60). This happens predominantly in public schooling and acts to include or exclude certain people both in and outside of the schooling institution (Rich & Evans, 2008). Dominant narratives push the idea of success as one that is uniform across all of society and must be achieved, regardless of weight, to be a good citizen (Gard & Wright, 2005). This aligns with neoliberal and capitalist ideals of success. Other participants similarly took up these discourses and found pride in related successes. Elizabeth in particular talked about being someone who did not want inadequacies in her work due to her weight.

> It's probably for me because I don't want to have inadequacies. And I don't want there to be reasons why I can't do things at the same level as everyone else. And I don't want to have to make excuses for myself just because of the size I am. Because I know that I can maintain my work level. It's just when you're being pushed to extremes sometimes it feels like your limit is a lot lower than some

other people. But I think it's mostly just myself thinking that. Because it didn't seem like anyone else was making out that it was that way.

For Elizabeth, weight was a barrier to her success, and she prided herself on being able to perform regardless of the size she is. This idea of needing to succeed regardless of weight was pervasive among the participants as they strived to be the best versions of themselves. Angela talked about being able to perform physically better than people who were younger and thinner than her.

> But I definitely act more like a 20-year-old than a 30-year-old. I'm still going outside and like, playing with my nephew. Like, I will run and chase him around the house, because I'm 30 and I should be able to do that. So, I make myself do that. I even had my sister's father-in-law comment on how active I was compared to the two 16-year-olds in the pool with the kids. So that made me feel like a great person.

Angela forced herself to be active with her nephew to avoid being stigmatized as a higher weight individual who is incapable of physical activity. She talked about being complimented on her physical ability as making her "feel like a great person", demonstrating how discourses of morality and weight may be incorporated by participants into their own ideologies and thought processes. Weight is a highly moralized subject. Gard and Wright (2005) explain that fatness is seen as a moral and personal failing in dominant discourses. In challenging the idea that higher-weight individuals are lazy and unwilling to exercise, Angela proved herself to be a moral citizen, distancing herself from the negative stereotypes that persist surrounding weight.

It is important to note that individuals are able to be prideful and avoid embarrassment without interpolating fatphobic discourses. Jordan highlighted this when talking about their behaviours that challenge fatphobic discourses and norms and being happy and proud of their position in fighting oppression through their existence.

> I think it took less courage for me and more anger and like more of me being tired of feeling like shit because of other people and like knowing that people were profiting off of that. And just like knowing that I was feeling like shit for no other reason than somebody wanted me to. And like why am I gonna let them have that satisfaction when I could love myself and be completely happy. […] Like I think it's just a lot of it has to do with like breaking out of the idea of like what's okay to do and like giving yourself permission and like recognizing that like people are gonna disagree, and people are still gonna be shitty, and people are gonna hate how you look, and people are gonna be really, really bigoted and horrible. But in existing you're fighting all of those things.

Jordan's pride in their fat identity provides hope for those supportive of a fat acceptance agenda for how other fat people might be able to exist in the future. Interestingly, Jordan showed strong emotions when they reflected on their journey of body acceptance. This may be because Jordan was rejecting their previous stoic behaviours or that Jordan's stoic behaviours are situational rather than comprehensive. Jordan's attitudes of self-worth are possible with more accessible education on how fatness is stigmatized in society. Jordan had a radical understanding of weight and fatness that was unique among the sample; however, Jordan stated that there are other people in society who will remain bigoted. Jordan emphasized the importance of fighting those

negative biases, stigmas, and stereotypes just by existing. They saw that more work must be done to better understand fatphobia and its implications to destigmatize fatness in society.

Response

The final aspect of the subscale stoic-fortitude is the theme of response. From the PAQ-R, response refers to the items "get on with life despite pain" and "go on as if nothing happened" (Yong et al., 2003). Throughout the data analysis stage, this morphed into patterns of how the participants responded to stigmatizing experiences and their subsequent lifestyles changes or lack thereof. Due to the complexity of stigma and coping mechanisms, many participants showed lifestyles changes in some situations but not in others. Some lifestyle changes included conforming to behaviours that match the dominant goals of fixing "obesity" while others involved resisting dominant "obesity" discourses.

Elouise talked about how she dealt with stigmatizing experiences with her doctor. On numerous occasions throughout the interviews, she showed evidence of changing her behaviours to match the dominant fatphobic approach to managing stigma, through dieting and exercising to lose weight. These behavioural changes are endorsed by Obesity Canada in the new clinical practice guidelines which state that various therapies that target the metabolic mechanisms triggered by decreased food intake and increased physical activity are positive and effective in managing "obesity" long-term (Wharton et al., 2020). Due to the importance placed on weight loss in recent clinical practice guidelines, it is not surprising that Elouise disclosed that she had a very negative

experience with her psychiatrist who kept prescribing her medication that incurred weight loss despite her complaints about feeling unwell while taking them. To cope with this, Elouise focused on achieving physical thinness rather than coping strategies for her mental health struggles.

> ’Cause I was trying to stay away from foods that I thought were bad. I don’t really know what foods are bad, but I was trying to stay away from chips and chocolate and any desserts, and I seemed more focused on that instead of trying to find ways to relax or occupy my mind.

This quote exemplifies her focus on eating habits instead of her mental health due to her psychiatrist’s focus on weight. Elouise shared in the interview that she had no internal desire to lose weight and that her weight loss attempts were to appease her healthcare team. This aligns with the symbolic interactionist interpretation of the self as being understood from the perspective of the generalized other, in this case from Elouise’s healthcare team. Also, it shows how the self can be protected through behavioural change to avoid negative self-perceptions. Elouise was not the only participant who changed her behaviours to match the dominant discourses of health and weight to protect her sense of self. Miriam also talked about changing her eating habits and exercise routine to manage weight since her healthcare provider refused to complete her hip replacements at her current weight.

> I’ve tried swimming. I like being in the water and I can move but when I go to get out, I feel like 1000 pounds. So, like my weight is 280 and I know myself I have to get weight down. But the only thing about the swimming is, it’s... Afterwards

> I'm so fatigued I can't even get my suit on. I'm no good for nothing and when I get home I gotta lay down, you know?

Miriam responded to weight stigma through exercising, even though it fatigued her so much that she could not complete her normal daily activities after. She clearly experienced a push to exercise even at the expense of other aspects of her wellness. Other participants responded to stigma through opposing dominant fatphobic discourses in their healthcare experiences and personal outlook. Judith refused to accept her healthcare provider's fatphobic and stereotypical response to her health problems. When her doctor told her that her health problems would be solved by losing weight, she responded by challenging his assumptions and his knowledge.

> And I said, so really? I said, how is that possible? I said that I've not gained all this weight for some odd reason over these years, and I've exercised my entire life and dieted my entire life, I said, trying to reduce my weight every day… of my adult life and yet I've had no results. And he's like, well, I just think you need to try harder. Right? So, I just got up and left his office. I didn't even say goodbye. Nothing. Just got up and left his office.

While the participant talked about dieting and exercising throughout her life, she had since realized that her weight and health are not directly and linearly linked, nor is weight loss a sustainable goal in the long term (Bacon & Aphramor, 2011), which was why she was able to stand up for herself. Judith ended up being diagnosed with a rare chronic disease, and it was through advocating for herself and not interpellating healthist and fatphobic messaging that she was able to get a proper diagnosis. Jordan talked about

the power of being able to be educated about weight stigma and how that allowed them to self-advocate and challenge dominant weight discourses in healthcare.

> It's gotten better in recent years […] and I think part of that is because I have stopped going to outpatients and just doctors in general and if I do, I am better at advocating for myself and I'm less meek and I feel like I don't necessarily give them the opportunity to. But I don't feel that it's like disappeared, I just feel like I've gotten lucky in my last few experiences.

Jordan talked about avoiding healthcare as a way of responding to stigmatizing experiences; however, they also talked throughout their interviews about being educated around fat liberation and how that affected their ability to stand up for themself in stigmatizing experiences. Jordan talked about being lucky in this regard, but many other participants had not been exposed to/endorsed body neutrality or the potential effects of weight stigma. These participants, like Jordan, were likely to avoid care all together to avoid stigma and protect their sense of self. This avoidance of negative experiences aligns with stoic behaviours that seek to avoid any sort of intense negative emotion, like the emotions that stigmatizing situations create. Penelope talked about how having negative experiences in healthcare can lead people to avoiding care all together to protect themselves from shame and stigma.

> This was a bad experience, like what if I go and get something checked out and it happens again. Then it makes them not want to go to the doctor if there's a problem. They kind of just stay home and kind of wait it out a bit and that makes them not want to go back. […] And so, it makes you not want to...I guess you may be feeling pain or stuff like, the pain versus emotional pain and you're like

> well… some people it outweighs so then they're like well, I'm just not going to go then. Or they end up having a fear of doctors or what they're going to say so then they just don't get checked out. Which is sad because there could be a big health problem, but then they're just too afraid to go. And then they're being shamed as well and all that kind of stuff. And it just becomes a big problem. They're like I don't want to deal with this anymore, so I'd rather take the pain than deal with emotional and, yeah, the emotional part of it.

Penelope brought up the important nuance of physical vs emotional pain. Many other participants talked about riding out pain and suffering at home rather than waiting for hours in an emergency room only to get stigmatizing and inadequate care. This pattern highlights the need to address the perceived lack of resources and training that emergency room physicians and staff often have according to the participants. On top of emotional pain and stigma keeping people away from emergency care, income can also be a major barrier to seeking care.

> Like, if someone's trying to travel to a hospital up north. It's a, like a $10-20 taxi ride. So, for a very low income, it's more difficult that way if you have to travel up there. And negative experiences could be a barrier because that just makes you not want to go. If you know, hey, I have this problem and I'm just going to be told to go home, I probably won't go. I've done that a lot myself. Like, oh, there's a massive pain in my side. It's like it'll go away. A doctor will tell me it'll go away, so. I just won't bother.

Ryan talked here about travel expenses and previous negative experiences compiling to create healthcare avoidant behaviours to avoid feeling more stigmatized.

The lack of adequate and non-stigmatizing care in New Brunswick is clear based on participant experiences and anecdotal evidence present throughout the interviews, like dismissing health problems as problems of weight and prioritizing thinness over mental and physical health. The experiences of the participants in this study were similar to those documented in other literature about weight stigma and healthcare (Pausé, 2014). The healthcare system needs to take an interdisciplinary and nuanced approach to promoting health access for all. Stigma responses can happen outside of healthcare experiences as well when perceived or internalized stigma is experienced (Mensinger et al., 2018). Many participants avoided certain behaviours that might be seen as stigmatizing, like trying on clothes that might not fit and eating in restaurants where others can see them. Elouise talked about how she would avoid eating in and would take her food out of the restaurants to eat at home since the seating in restaurants is inaccessible and is a potential site for stigma.

> Like if my husband wants to take me out, it's like (laughs) okay we're going to have to get a restaurant that the chairs move, or I'll just want to eat in the car or whatever. Like 'cause the McDonalds and Wendy's are kind of bad. Like they do have some places that I like to sit at the booth. And the booth is not moveable. So yeah, it effects it, if I pick that restaurant or not, or am I feeling like I want to be squished or, (laughs) ... Also, at Costco 'cause I barely fit in there too... Being overweight effects where I want to go because it depends on how far we're going to have to walk or am I going to have a chance to catch my breath when I get there. So yeah, weight kind of just effects every facet of my day.

Elouise showed just how much inaccessibility affects the lives of higher weight

individuals who have to take their food out rather than dining in. This problem was prevalent among other participants who talked about not fitting in chairs in dining areas, worrying about their stomachs coming over top of tables when the seating is fixed to the ground, and having to sit in the wheelchair accessible places just to have enough space to be comfortable. In some instances, this led to social isolation as participants try so hard to avoid being stigmatized. This was the case for Penelope who struggled with anxiety relating to her weight and others' perception of it.

> So, I deal with a lot of anxiety. And so even, it comes down to the point where I'm like, if they think I'm bigger and stuff and then what else do they think of me? And then, sometimes I don't even go, like there's been times when I don't even want to go out like after practice, out with [my rugby team] because I'm like well, I want to pick this to eat but I'm like well, what if they say oh, well why are you eating that? […] And they, and it's even gotten to the point where I don't like it when people watch me eat too. I kind of just go home. I don't like going to restaurants because I'm like oh no, people are going to watch me eat and like...Not because I'm messy. It's just because like, why is she ordering that and things like that. I don't think about it a whole lot because I don't go out because of that, but when I do, I'm with my family and they're like oh no, let's go out to eat, I'm like mmm, okay. So, I don't, sometimes I don't even finish my full meal because I'm afraid of what people, other people around me are thinking about me eating.

The fear of being judged by her peers forced Penelope to avoid eating socially with her friends and caused her to not eat her entire meal even when out with family. The

pervasiveness of weight stigma majorly impacts the lifestyles of higher-weight individuals who are living in a fatphobic society. The participants' responses to stigma showed evidence of stoic behaviours in the form of avoiding strong negative emotions to protect their individual sense of self. Some participants did this through conforming to dominant discourses of weight and exercise norms while others actively spoke out against fatphobic behaviours. However, most commonly, participants avoided healthcare, shopping, and eating experiences where they worried about being judged and being stigmatized for their weight. This caused numerous negative health outcomes by participants avoiding potentially helpful health services, social isolation, and disordered eating patterns among participants.

Avoiding future potentially stigmatizing and negative places is a common manifestation of many of the separate themes. This is to be expected, as stoicism results in the avoidance of negative emotions or pain, both physical and emotional. It also showed that each theme is often inseparable from the others. For the purposes of analysis, the themes were separated, but in reality, many of the stoic behaviours act together and produce similar behavioural effects, like avoidance. Stoic responses to stigma can have major negative impacts socially, mentally, and physically for these participants. It is unclear whether these behaviours impact broader society, but this could be a direction for future research. Interestingly, the participants also showed the positive implications of adopting certain stoic behaviours. In deploying a stoic response, participants often prevented negative emotions and specific instances of stigma, which can be beneficial for their overall wellbeing in the short-term. The long-term emotional effects of stoicism are still under researched. The use of stoicism to cope with stigma is very nuanced. From

these data, it appears that stoicism can have both positive and negative implications for the participants.

Stiff Upper Lip

The final theme that is part of the stoic-concealment subscale is having a stiff upper lip. Stiff upper lip refers to one item in the PAQ-R, which is keeping a stiff upper lip during painful (stigmatizing) experiences (Yong et al., 2003). This theme remained fairly unchanged in its description as it emerged from the data. For participants, this led to behaviours like excusing stigma and putting up with pain, stigma, or negative emotions instead of seeking care or confronting systemic barriers. Participants kept a stiff upper lip in both healthcare experiences and everyday life. Judith talked in her interview about avoiding care for her allergic reactions due to her past mistreatment by healthcare professionals.

> So, my sister has the same disease but just not as intense. There's two types of mass cell patients. There is a leaker and a shocker. I leak myself constantly. She, hers build up and then she goes into anaphylactic shock. Right. So, she goes to hospital four to six times a year, with the anaphylactic shock. When I have reactions, I don't go, I just give myself the Epi pen and wait it out because it's low grade enough. Doctors wants me to go, but I won't go because of how I've been treated.

This participant has a chronic condition, which caused her to have low-grade allergic reactions often. While her doctors wanted her to go to the hospital to be treated, Judith avoided seeking care due to previous stigmatizing experiences. Instead, she kept a

stiff upper lip in the face of pain and allergic reactions and deals with them herself. Other participants also kept a stiff upper lip in the face of pain and negative healthcare experiences. After having some negative experiences, herself and witnessing very negative experiences that her friend had, Angela was very unwilling to return to the emergency room at the hospital.

> I would just take a Tylenol at home and go to sleep and hope it goes away or something like that. But that would be about it. Other than ... I probably will never go back to the ER unless I can't breathe, or my heart is failing. So that's about the only time.

Angela showed a classic example of keeping a stiff upper lip through managing her pain at home and suffering through it until it hopefully goes away. However, certain health complications like heart failure would still bring Angela to the hospital if she is able to recognize symptoms, proving that major health concerns can override stoic behaviours when they are serious enough. Ryan also kept a stiff upper lip and avoided seeking care when dealing with his degrading eyesight since he was unable to afford going to the optometrist and buying glasses.

> Because my income and I don't usually have insurance, like where I just went to college, the insurance is not good. So, I haven't been to a dentist in four or five years. And before that, I hadn't been to one in 10. With stuff that's not covered with insurance, low income is a huge barrier. I'm going blind. I need that care. So, I know what to do, but I know it's going to cost $200 to do anything. I can still mostly see. I just got to squint.

Ryan also talked about not being able to afford dental care as someone who was uninsured and living on a low income. This showed that stoic behaviours can be triggered by income barriers as well. Somewhat differently, Jordan also managed to keep a stiff upper lip when faced directly with stigmatizing experiences. They had extremely stigmatizing and negative experiences with mental health care providers specifically, but they have learned how to maintain a stiff upper lip to avoid adopting fatphobic viewpoints.

> And also, like trying to like ground myself in the progress that I've made and recognize that no matter what the nutritionist or psychiatrist or therapist says to me, I've probably already heard it before. And like I don't have to give it power. Like they'll say it and it'll be hurtful, and it'll be damaging, but it's not any more hurtful or damaging than the other things that I have already distanced myself from. It's just a matter of it's coming from a person in a position of authority which is like my health provider.

Jordan distanced themself from stigmatizing discourses maintained by psychiatrists and nutritionists as a way to keep their stiff upper lip. Jordan talked about how they have already done significant emotional work to distance themself from the damaging fatphobic discourses and comments that they have received through their life. Their ability to be educated about the negative implications of fatphobia helped them maintain that emotional distance and keep a stiff upper lip in the face of stigma.

Participants also kept a stiff upper lip in experiences in their daily lives. This pattern emerged in painful, stigmatizing, and generally negative situations. Angela talked about how she managed her weight while navigating the inaccessibility of chairs in

public spaces. Angela and her mom both placed more weight in their legs to avoid an embarrassing situation if the chair were to break while they were sitting on it.

> Like even right now, me sitting on this chair I'm probably pushing all my weight to my legs. Cause I don't want the chair to buckle out under me. But that's just something I do without even thinking I'm doing it. And my mom does the same thing. My legs are so strong.

Angela talked about this being a protective behaviour that she did without even thinking about it. When asked if her legs get tired or sore, Angela said that they do not since she was so used to it. Angela clearly kept a stiff upper lip in the face of discomfort to avoid stigmatizing experiences due to her weight. This level of tolerance to discomfort coincides with stoic behavioural patterns. Judith also talked about keeping a stiff upper lip in the face of discomfort due to her chronic illness that hinders her mobility.

> I'll take my two canes and people that see me ... Because I still exit by the garage door where it's flat. And people say, "Oh my God, you must be feeling better. You're not using your wheelchair as much." I'm like, "No." I said, "Unfortunately, the handi-bus doesn't run on the weekends." […] So, I had to take my canes and hobble my best through it, and then their expression changes because they were expecting, oh yes, I'm feeling better, I'm also getting better. Right? But a lot of people just don't realize that most people get into these, this situation, being in a chair you never get out. It's progressive.

Due to lack of availability for accessible transit, Judith had to struggle through pain, discomfort, and fatigue by taking her canes instead of her wheelchair. Judith maintained her stiff upper lip and it is clear that she was acting according to certain stoic

behaviours when she talked about hobbling through the discomfort the best she can. While a lot of these stoic behaviours are seen as negatively impacting the quality of life and care of participants, Jordan talked about how keeping a stiff upper lip, in combination with therapy, had helped them shift their thinking about their body and their experiences.

> And like which is a huge feel for me too, which is just like recognizing that something is true even if you don't believe it. And like I still- like I'll practice that with so many things. Like if something will give me anxiety or whatever I'll say like x, y, and z is happening, and I'm good. And it's good. Like I'm good and it's good. And like even if I don't believe it at first like verbally saying that convinces your body. And then eventually you're able to fully believe it.

Jordan practiced telling themself that they are "good" regardless of their anxious feelings as a way of coping with negative situations. Maintaining that everything is "good" is a way of keeping a stiff upper lip. However, it is important to note that this behaviour was done in concert with psychological and psychiatric counselling and is not necessarily an outright suppression of feelings.

Keeping a stiff upper lip was protective for participants in many instances within and outside of the healthcare system. It was a way for participants to avoid negative self-perceptions and intense negative emotions, which when done in healthy ways, can be an important and positive coping mechanism.

Tolerance

The theme of tolerance is very similar to the themes of having a stiff upper lip and endurance. However, tolerance is not looking at a duration of time in the same way that

endurance does. Also, tolerance is different from keeping a stiff upper lip since it is part of the stoic-superiority subscale which adds a level of comparison to others. From the PAQ-R, tolerance is related to the item of "tolerate more pain than others" (Yong et al., 2003). The theme is described as the level the participant feels they can "handle" or "tolerate" stigmatizing experiences compared to others. Interestingly, this theme adds a nuanced perspective of stigma and includes instances when participants have an acute awareness of how they "should" be reacting to stigma versus how they are reacting to it. Angela talked about how she felt she "should" react to being stigmatized in a healthcare setting.

> Sometimes you get the weird looks from them, like they look you up and down type thing, because my best friend is probably a ... she's the skinniest thing I've ever met. And she's my best friend, so when we stand side by side, it looks kind of funny sometimes. So, I go to her doctor appointments with her for her baby, they kind of look at me and they're like, "Hmm." Like, and I've seen doctors do it to me and I've seen nurses look at me weird for that way, but it doesn't bug me as much as it probably should, but it's strange.

Angela understood that she should be viewing this situation as negative and stigmatizing, as others might, but due to her thick skin that she talked about throughout her interviews, it did not "bug her". For Judith, this comparison to others made her proud of her tolerance.

> I had always struggled with this. And the geneticist said to me if you hadn't strived to [maintain exercise] you probably would've been sicker 20 years ago. He said but because you maintain the health, because you maintain the exercise,

to prove yourself, to keep your weight down, you've strengthened all the muscles around your bones, you've kept your joints together. He said a lot of people with Ehlers-Danlos by the time they're 30, they can't work. You know, he said they can't walk, they're in crutches and braces.

Judith tolerated pain and misdiagnosis throughout her entire life but found pride when she compared her struggles to others. Her geneticist told her that without her tolerance and drive to push herself through the pain, she would have been worse off, like others who have her condition and have deteriorated more quickly. This showed the protective nature of stoic behaviours like tolerance. For others, tolerating pain, stigma, or discomfort was less protective. Elizabeth talked in her interview about tolerating discomfort while she did not have insurance or funds to pay for certain medical procedures or resources.

Things like getting fillings or root canals or whatever that you need or losing your teeth. Or I mean for me getting, I've had to get braces, I've had to get glasses, I've had to get insoles for my feet. Those all cost quite a bit. A pair of insoles is like 400 some dollars. Braces are several thousand. And I mean some of those are cosmetic but some of those also will help with issues later on down the road. I've had to get my wisdom teeth out. A lot of people can't afford to do that and the pain's just gonna keep on getting worse and worse. So yeah. The money side of things is gonna be a big factor. I haven't had to deal with that too much. I have waited for fillings until I have insurance again. But it hasn't been significantly worse because I haven't had to wait a long period. So, for me it hasn't been bad.

Elizabeth talked about how she was able to tolerate waiting to seek care better

than others due to her financial state, where she did not have to wait long before she had access to insurance again, compared to others. Other participants, like Avery and Trevor, also talked about how income forced them to tolerate stigma or inadequate care. Trevor talked about not minding the wait times for the ER. He lived on an extremely low income and was sometimes forced to rely on inadequate care.

> If it's something more serious, I just wander up to emergency and I prepare myself for a long wait. And I don't mind that because whatever it is is serious enough, and I'm willing to play the game and sit there. Uh, and most times it's not that bad. Um, so that's okay.

Trevor said he did not mind the long wait times compared to others who often complained about waiting in the emergency room for hours when seeking care. This level of tolerance was a form of stoic behaviour. Avery talked about how this tolerance builds up, and when people are disadvantaged, they often have no choice but to tolerate stigma or poor care.

> Also, people need to realize that it's ... like, self-fulfilling prophecy is a very real thing. Whether or not it's ... your parents did it, so you do it. Or, like, "I have to keep this job, even though it makes me upset because, what if I can't find another one?" Or "I've always been told that I'm stupid, so I'll just act like I'm stupid." All of those little things, they are just self-fulfilling prophecies that are very, very hard to break out of. Because either you can't or, when you try to, you get shut down, and then you never want to again. Or you constantly get shut down, and then it never works, and then you don't do it again. Very rarely do people break out of those. On their own. And weight is the same. Income is the same. I can't

> change the fact that I'm a woman. I can't change the fact that, like ... Again, luckily, my family doctor is female but, like, if I had a male family doctor, I'm not going to leave that family doctor, because at least it's a family doctor. Right? So, in New Brunswick, that's not something I can change. […] So, you just take it one step at a time.

Not having the resources to change things like who your family doctor is in New Brunswick forces disadvantaged people specifically into tolerating stigma and inadequate care. For low-income, higher-weight, and other marginalized people, their choices and freedoms are limited, which forces them into stoic behaviours. As seen above, some of these behaviours can be protective; however, many of them are not. Tolerating stigma or pain can cause people to not seek care, allow their conditions to get worse, or not speak up when they receive incompetent or oppressive care.

Through analyzing each of these ten themes, it is clear that stoic behaviours can be deployed in discrete situations. Each participant described instances where they deployed one or more stoic behaviours to manage stigma and to avoid negative emotions such as shame or embarrassment. The data shows that although each participant showed some stoic behaviours, stoicism was not deployed ubiquitously. When possible, many participants avoided healthcare to respond to stigma or attempt to control stigma or others' reactions to them. If avoidance was not possible, participants would often uptake fatphobic discourses and self-stigmatize, placing blame on themselves and typically hesitating to label the experience as stigmatizing. Alternatively, participants would distance themselves from strong emotions, boasting a tolerance for stigma or a stiff upper lip in the face of stigmatizing experiences. It remains difficult to say whether or not the

participants would describe themselves as stoic, as the questions asked in the interview were not directly related to stoicism. However, the implications for healthcare and policy remain the same and acutely important.

CHAPTER 5: ADDITIONAL FINDINGS & IMPLICATIONS

This research aimed to understand the use of a stoic ideology amongst higher-weight, low-income individuals by answering the following questions:

1) How do stigmatizing experiences affect the development/adoption of a stoic ideology amongst higher-weight, lower-income individuals?
2) How does this coping mechanism affect health seeking behaviours and healthcare experiences?
3) How do stigmatizing places and spaces affect the deployment of stoic behaviours?

I found that weight and income stigma in both healthcare and non-healthcare related experiences influenced the development of certain stoic behaviours among all the participants. Often due to the interpellation of prevailing and systemic stigma and barriers, participants developed and deployed stoic behaviours like keeping a stiff upper lip, responding through behavioural changes (avoidance of healthcare or stigmatizing places, conforming to weight based discourses, and self-education/advocacy), attempting to control the stigmatizing situation or the responses from others, etc. Often this led to healthcare avoidance among the participants, who would rather manage their healthcare concerns on their own than experience further stigma from healthcare professionals.

Participants would also withhold certain information from healthcare providers or delay serious care to avoid stigma. When participants could not avoid seeking care, some would self-educate so they could better advocate for themselves, or distinctly distance themselves from the strong emotions connected to stigmatizing experiences. Similar coping mechanisms were used when participants experienced stigmatizing places or spaces in New Brunswick. Avoidance of those places was the prominent coping

mechanism. When avoidance was not possible, many participants would distance themselves from the negative emotions related to stigmatizing experiences, like shame or embarrassment. Other participants were reluctant to declare certain spaces as stigmatizing and instead would turn inwards to find personal reasons why the space was negative for them rather than blaming the structural barriers. Each of these findings will be discussed in more detail in the following sections.

The Development of a Stoic Ideology

It became clear that a stoic ideology is not fully present among any of the participants. For Pathak et al. (2017), a stoic ideology is not deterministic; rather, it informs an ideal set of behaviours that individuals aspire to fulfill. However, there was evidence that most participants only used certain stoic behaviours to manage stigma and systemic barriers rather than ascribing to a personal ideology. These stigmatizing experiences included but were not limited to feeling judgement or dismissal by healthcare professionals and lay people, receiving poor or judgmental service due to weight or income from employees in restaurants or retail stores, weight-based teasing or negative comments, and self-stigmatization from ingrained neoliberal discourses and fatphobic health messaging. For this research, stigma included issues of structural and systemic barriers that disproportionately affected the higher-weight, low-income participants. Many participants deployed stoic behaviours to cope with systemic barriers including inaccessibility of buildings and public transit as well as a lack of education and resources surrounding higher-weight and/or low-income specific care.

Pathak et al. (2017) attempted to move towards viewing stoicism as a fully formed ideology rather than a set of behaviours. For Pathak et al. (2017), stoicism was described as a personal ideology that acts "as a guide to ideal self-conduct" (p. 3). As part of this definition, individuals who adopted a stoic personal ideology created ideal expectations of themselves, which required continuous enforcement and behavioural changes to accomplish. However, Pathak et al. (2017) were working from a biomedical health perspective. When analyzing behaviours through a sociological lens, it becomes clear that stoicism can be understood in a non-ideological way and that this may be more valuable for a sociological analysis. The way that Pathak et al. (2017) understand what they call a stoic ideology is deterministic in nature and does not allow for the nuance and complexities of individuals' experiences and coping mechanisms.

Through taking a more expansive approach to understanding stoicism, the data revealed partial adoption and deployment of stoic behaviours that otherwise would have been missed through an ideological lens. The data did not suggest that any of the participants deployed a complete stoic ideology, but by understanding the stoic behaviours both individually and in conjunction with one or more other stoic behaviours, I was still able to analyze the distinct impacts that stoicism and stoic behaviours have on healthcare experiences and health seeking behaviours among participants. Understanding stoicism through this behavioural and material perspective may be more useful for understanding the complex behaviours of the participants. To my knowledge, there is no other literature that takes a distinctly materialist perspective on understanding stoicism.

To understand how stoic behaviours are deployed in these stigmatizing instances, we must first understand the intersection of the stoic behaviours that have been discussed

previously. While the previous section talked about each theme as discrete behavioural patterns, in reality these themes and associated behaviours were often overlapping when managing stigma. For example, the theme of internalization offers a way to understand certain stoic behaviours. Participants like Jordan and Elouise talk about how they personally have interpellated certain fatphobic discourses, like feeling like a burden to others when asking for help and accepting that healthcare professionals "know best" regardless of their stigmatizing beliefs. There is a plethora of anecdotal and academic literature surrounding weight stigma and the interpellation of fatphobic discourses such as these, predominantly among American women (Pausé, 2014; Mensinger et al., 2018). Pathak et al. (2017) also explain that the development of what they deem as a stoic ideology, but what I conceptualize as stoic behaviours, is heavily based on the uptake of specific stoic ideals. This includes a strong hesitancy to ask for help, which might explain the uptake of discourses stating that fat people are a burden to healthcare and those around them.

Due to this interpellation, both these participants and many of the others adjusted their behaviours, as seen in the response theme; or, attempted to control their emotions or the situations they were in, as seen in the control theme. This often led to healthcare avoidant behaviours, which are known to have negative health impacts, like the avoidance of cancer screenings and individuals opting to cancel or postpone appointments out of fear of being reprimanded or harassed due to weight (Mensinger et al., 2018; Pathak et al., 2017; Pausé, 2014). The overlapping nature of the internalization, control, and response themes are not the only themes that are closely tied to each other. The themes of emotional response and response are highly connected, as an emotional

response to a stigmatizing event often triggers a behavioural response as well. Other themes like tolerance, stiff upper lip, and endurance often overlap and there are only small discrepancies between each of the themes.

Using a nuanced perspective to analyze the intersections of the previously separated themes, we can see more clearly how certain stigmatizing experiences impact the development of stoic behaviours. When looking at how the participants responded to weight stigma through behaviour changes and emotional regulation, the development of a unique set of certain stoic behaviours is illuminated in each participant.

When participants faced weight stigma in healthcare, one of the most common coping mechanisms was to avoid seeking care again unless they were presenting with a particularly severe health issue. For Jordan, this meant avoiding going to the doctor for six years. Jordan's experiences were not unique to them; many other participants spoke about avoiding healthcare to avoid "lectures" about their weight from doctors or dismissal when discussing chronic pain or other health challenges. Doctors often assumed all healthcare problems were related to the participants' weight, which aligns with findings from an abundance of literature from critical weight scholarship (Bacon & Aphramor, 2011; Bombak, 2014; Davies, 1998; Dickins et al., 2011; Gard & Wright, 2005). In many cases, this avoidance of healthcare professionals coincided with an uptake of other stoic behaviours, like keeping a stiff upper lip and being able to tolerate stigma. Participants like Ryan and Elouise would keep a stiff upper lip regarding pain instead of being treated by a healthcare professional to avoid stigmatizing experiences due to their weight. Other participants spoke about their ability to tolerate stigmatizing experiences in healthcare through behaviours like keeping a stiff upper lip when doctors spoke about

their weight in a negative way. It is easy to see how this leads to mistrust in healthcare professionals and diminishes the quality of care that higher weight individuals receive from healthcare professionals.

Participants also talked about how they coped with weight stigma in their daily lives, outside of healthcare interactions. Again, there was evidence among the participants that they developed certain stoic behaviours to manage the stigma they faced. Angela talked about the development of her "thick skin" as a coping mechanism for being teased about her weight throughout her life. As an adult, she has been able to distance herself from the strong negative emotions that come from weight-based teasing and stigma due to this coping mechanism.

How Angela talks about her "thick skin" is emblematic of the experiences of many of the participants. This "thick skin" was used as an explanation of coping when participants were subject to weight stigma throughout their entire lives. Analyzing this coping mechanism from a stoic perspective, it bears similarities to keeping a stiff upper lip and having better tolerance towards stigmatizing experiences than others. Their long-term exposure to stigma forced them to develop coping mechanisms that we can understand in the colloquial way of having a "thick skin", and in the biomedical parlance resembles stoic behaviours. Being able to articulate these colloquial coping mechanisms through academic terms acts to legitimize them in scholarly literature and can add to the body of knowledge surrounding weight and income stigma. Lavallee et al. (2016) found that the inclusion of patient and participant recommendations in care procedures enhanced patient engagement and level of care provided. This also helps to inform proper and non-stigmatizing care procedures that are patient-centered, like treating disease instead of

BMI and staying up to date on the most recent literature on providing adequate healthcare for fat patients (Pausé, 2014).

When looking specifically at low-income stigma, participants spoke more about barriers to care or services due to their income rather than overt stigma. Using Link and Phelan's (2001) definition of stigma, structural barriers act as a form of institutional stigma that has major negative impacts on stigmatized individuals and "stigmatization in general negatively impacts population health through structural oppression," (Mensinger et al., 2018, p. 140). Therefore, I will be writing about stoicism relating to income from the perspective of stoic behaviours being deployed due to lack of personal resources or governmental services. The most common barriers for low-income individuals were lack of affordable, fresh foods, poor public transit, and lack of low-income specific healthcare resources. Additionally, stigma was present in the forms of judgement due to appearance and lack of empathy from healthcare professionals when systemic barriers were present for the low-income participants.

One of the most prevalent barriers for low-income individuals was lack of access to adequate public transportation. For many participants, public transit, like city buses, was their main source of transportation to their jobs, healthcare appointments, and essential trips to grocery stores or food banks. Lack of accessible transit for many participants meant not being able to purchase frozen foods or get frozen goods from food banks because they would melt and spoil before they were able to get home. Since frozen goods are cheaper and last longer, these types of food were often cited as ideal food sources among the participants who are all living on a low income. However, poor public transit systems meant having to purchase more canned foods and more expensive fresh foods or

forced the participants to rely on their social network for rides to/from grocery stores and food banks. This reliance on their support network was uncomfortable for many participants who felt burdensome when reaching out for help.

The problems with public transit also affected participants' ability to work or advance within their jobs. Some participants talked about walking for hours to work which, for Penelope, meant she was unable to expand her cleaning business and had to pass up on opportunities to advance in the world of entrepreneurship. Other participants who relied on public transit were forced to spend hours riding buses to get to their jobs or appointments and would be constantly worried about missing a bus and being stuck without transportation until the next one arrived, which could take hours.

The stress of using a flawed public transit system disproportionately affects low-income individuals (Foth et al., 2013). Lack of funding and prioritization for transit functions to disenfranchise low-income individuals in New Brunswick and is a clear example of how the government is governing predominantly for the elite members of the province. Literature suggests that "transit access should be available for populations with the greatest potential need for subsidized transport," (Foth et al, 2013). Those who have the greatest need for subsidized transport are often low-income individuals, who get trapped in a negative cycle of not being able to afford transit and are therefore not able to get to a job. This spirals again into still not earning an income high enough to afford any transit. Higher-weight, low-income individuals already face stereotypes of being lazy and staying on welfare instead of finding work (Gard & Wright, 2005; Foth et al., 2013). Inaccessible transit that continues to disadvantage higher-weight, low-income individuals helps to perpetuate these stereotypes. There is a need to address the systemic barriers and

institutionalized stigma that allows for the continuance of an inaccessible public transit system.

Each participant had their own unique set of stoic behaviours, which are a collection of overlapping strategies that are deployed in various ways depending on the stigmatizing situation or systemic barrier each individual faced. Each experience called for a unique response, which can include stoicism in some instances but not in others. Unlike Pathak et al.'s (2017) understanding of a stoic ideology, this data shows that stoic behaviours can be used separately and partially as ways of coping with stigmatizing experiences as well as systemic barriers. To answer the question of "how do stigmatizing experiences affect the development/adoption of a stoic ideology amongst higher-weight, lower-income individuals?" the data shows that the collection stigmatizing experiences and systemic barriers each participant faces is unique, however patterns in the deployment of stoic behaviours were noted. The most prevalent stoic response was to avoid healthcare or stigmatizing experiences in general to evade the negative emotions associated with stigma or systemic barriers.

Healthcare and Health Seeking Behaviour

Participants who used stoic behaviours as coping mechanisms for stigmatizing experiences and systemic barriers often changed their health seeking behaviours and how they engaged with their healthcare experiences. In line with other research on stoicism in healthcare (Pathak et al., 2017; Latimer et al., 2014), participants exemplified stoic traits like having a stiff upper lip and controlling stigmatizing or negative experiences through emotional responses and behavioural change. Importantly, for many participants this

impacted their health seeking behaviours, which can have major implications. After stigmatizing experiences in healthcare and in daily lives, the most prominent change in behaviour among the participants was to avoid the place of stigma, whether that was a particular store, being with a particular individual, or engaging with the healthcare system. Adopting stoic ideals and behaviours leads to an evasion of necessary help from professional and personal support networks, leading to negative health consequences (Pathak et al., 2017). This type of behaviour and healthcare avoidance can lead to the progression of medical problems to the point of developing advanced forms of illness that otherwise could have been treated (Latimer et al., 2012).

Other stoic coping behaviours, like having a stiff upper lip or tolerating stigma in healthcare experiences lead to misdiagnoses and miscommunications in healthcare visits. This is true amongst other stoic patients, like Indigenous children in their healthcare experiences (Latimer et al., 2014). Having a stiff upper lip resulted in minimal communication about pain with healthcare providers. This change in communication style did not coincide with typical diagnostic or assessment tools, meaning that healthcare providers would often remain unaware of the pain that the Indigenous children were experiencing, leading to misdiagnoses and poor communication between the doctor and patients (Latimer et al., 2014). The ways in which having a stiff upper lip affects healthcare communication has not been tested in other diverse populations; however, it is possible that this stoic behaviour has similar outcomes among higher-weight, low-income individuals.

When the participants did not avoid healthcare experiences all together, they would often avoid talking about specific health issues that might be dismissed as weight related

issues. For example, Elouise talked about withholding her pain from her doctor because she expected him to lecture her about weight loss again and how her weight must be the cause of her knee and hip pain. Avery also shared similar sentiments and after being told her leg pain was due to her weight, even though it started after a car accident, she avoided talking about the pain with her doctor again.

The feeling of distrust with doctors is a common predecessor for the development of stoic behaviours in healthcare experiences specifically (Latimer et al., 2014). For the participants who did not express their medical issues to their healthcare professionals, several coping mechanisms were deployed. For some, physical behaviour changes needed to be made, like sitting to do the dishes to avoid untreated pain. Others "toughed it out" with mental resiliency and acted as though the pain or discomfort did not exist until it passed, and they were able to live their lives without pain. For some, when the pain became unbearable, they were forced to seek medical attention from stigmatizing professionals who often said something that would negatively affect the participant's mental health. Education and anti-stigma training must be a priority to adequately care for low-income, higher-weight individuals so that the development of stoic behaviours can be moderated.

Compounding this, the deficiency of adequate and affordable public transit once again affects the lives and behaviours of low-income individuals. When looking specifically at health seeking behaviours, the lack of transit can be a major barrier and deterrent from seeking care. Some participants, like Ryan, talked about how expensive taxi rides to the hospital are in his city. Due to the financial barrier, Ryan explained that he would avoid going to the hospital or to see a doctor and instead would wait for the

pain to subside, exemplifying how stoicism, particularly having a stiff upper lip, can be a result of the barriers associated with living on a low income. Ryan was not the only participant who avoided healthcare due to lack of affordable transportation. Judith talked about having to travel to Halifax to see a specialist for her rare, chronic illness. As someone who is living on a low-income, she was unable to afford the travel costs associated with seeing the specialist and had to settle for less specialized care.

Judith also struggled with city transit being accessible to her as she predominantly had to use a wheelchair due to her chronic condition. When the designated handi-bus was unavailable, usually on weekends, Judith had to stay in her apartment or rely on her elderly parents or other members of her social network to take her on errands or to healthcare appointments. As Judith mentioned, this would often cause her to feel like a burden to those around her and she would avoid asking for support. She talked about the negative mental health and social impacts of this lack of independence, stating that it made her feel depressed and less likely to go out and enjoy herself outside of her home. This highlights the loss of independence that many low-income participants felt when they were forced to ask for help due to inadequate public resources. However, when Judith was asked about positive places during her interview, she talked openly about how important it was to have accessible places when she could meet with friends socially and regain some independence, proving the importance of accessible public spaces.

Some participants faced overt stigma during healthcare interactions due to their income. Most commonly, participants talked about their doctors either not being able to offer low-income specific resources or healthcare professionals who were unwilling to accept the struggles that low-income individuals face as barriers to healthful behaviours.

Many participants who saw dieticians or nutritionists at some point in their lives spoke about how these health professionals were not well equipped to provide nutrition advice to individuals with a small budget. In fact, "written nutrition education interventions have been developed mostly for middle-income, non-minority populations" (Strolla et al., 2006, p. 465). This shows the favouring of middle- and upper-class eating habits and lifestyles by institutions of power, such as the healthcare system and education institutions. Literature shows that both nutrition and medical students lack socioeconomic diversity and medical students feel most comfortable caring for and treating people with similar life backgrounds as them (Riediger et al., 2019; Khan et al., 2020). This has major implications for nutrition and healthcare for low-income individuals who are not represented in the general body of medical professionals (Khan et al., 2020).

Elouise also described elitism among healthcare professionals during her interview. She talked about how her primary care physician would not accept her low-income status as an "excuse" for not being able to buy fresh fruits and vegetables to promote good health. This attitude seems pervasive among healthcare professionals spoken about during the interviews who operate in elite circles and, due to their socially legitimated power, are often not held accountable for potentially classist and ignorant beliefs about income-based inequalities in New Brunswick (Low, 2016). Penelope spoke about the lack of information and informed care being a source of healthcare avoidance and shame. This led to her adopting stoic behaviours like trying to impose control over how people perceive her and her eating habits when she eats foods typically associated with living on a lower income to avoid stigma. This was especially apparent when Penelope was referred to a nutritionist to see for the duration of her first pregnancy. During the first few

interactions with the nutritionist, Penelope felt shamed by her nutritionist and avoided future appointments regardless of her needs, showing a level of stoicism through having a stiff upper lip and controlling the situations in which she engaged. Penelope's situation is exemplary of the stigma and barriers that low-income individuals face in New Brunswick. These barriers and classist attitudes leave low-income New Brunswickers with a lack of income-informed, adequate healthcare that properly addresses their needs.

Stigmatizing Places and Spaces

The study also collected data on stigmatizing places and spaces in New Brunswick. While it has not been a focus throughout the results and discussion thus far, understanding how the participants interacted with stigmatizing places can give insight into the development and deployment of stoic behaviours. Predominantly, places that were characterized as negative or stigmatizing were often inaccessible physically and/or financially. Spaces that were inaccessible had similar traits, including lack of wheelchair accessibility, small aisles, or limited/lack of seating for higher-weight individuals. Many of these accessibility issues are echoed in critical literature that assess the impact of spaces on weight and stigma, stating that accessibility issues reduce mobility and increase stigma amongst higher-weight individuals (Kirkland, 2011; Colls & Evans, 2014). These structural barriers are forms of institutional stigma that can negatively impact the lifestyles and wellbeing of the participants who experienced them (Link & Phelan, 2001). Additionally, participants were more likely to label spaces as negative if they perceived weight- or income-based biases among the staff or other patrons of the particular place. Participants explained that these perceived biases included staff in retail stores not being

friendly to them or offering to help due to an assumption that nothing in the store will fit them or their budget. Other perceived biases were negative or judgmental looks and an unwillingness to try to help improve accessibility in the spaces.

To cope with these stigmatizing spaces, many participants avoided going to the places all together or minimizing time spent in the spaces when they cannot avoid them entirely. Elizabeth talked about this a lot during her interview. When she found spaces either stigmatizing or inaccessible to her due to her size or income, Elizabeth would cut them out of her life to avoid the negative emotions that were related to the particular space. This type of behaviour was prevalent among other participants and can be understood as control from a stoic perspective. Elizabeth, and other participants, controlled their outings to manage stigma and effectively avoided the negative emotions associated with stigma as well.

Overall, many participants did not label these places as stigmatizing, even when they did recognize the negative impacts the places had on their wellness. Rather than labelling places as stigmatizing, many participants justified their negative experiences through discussing how places cannot always change their layout to be more size accessible, especially in public historic buildings. The participants would often make excuses for the staff and other patrons, stating that staff in retail spaces might not know how to interact with patrons that the store does not cater to (i.e., higher-weight individuals who are shopping in size exclusive clothing stores). Participants would also justify judgmental looks from those staff in retail spaces as a self-consciousness or something that they are making up in their heads. The participants would explain that due to years of stigma and judgment based on their size, they are more likely to assume that

others are staring at and judging them, claiming that it is a personal insecurity instead of a real behaviour portrayed by the staff. Many excuses were made to avoid blaming stigmatizing spaces and people – potentially so participants could distance themselves from the stigma they were experiencing. This unwillingness to label experiences as directly stigmatizing is an example of stoic behaviours being developed and deployed in response to stigmatizing spaces.

Contrasting the discussions around negative spaces in New Brunswick, participants were also asked about places that positively impacted their wellness. These were places where participants were able to feel more comfortable as higher-weight, low-income individuals. Common traits of these spaces were that they were low-cost, casual spaces where individuals could feel supported in their weight and income. Places that specifically catered to higher-weight, low-income individuals were also positive for the participants. In these spaces, the participants did not need to employ their stoic behaviours, showing that stoic behaviours are often not deployed in non-stigmatizing places or when not managing stigma. Spaces that catered to higher-weight and/or low-income individuals offered a respite from the stoic behaviours that these participants used when coping with stigma. In these spaces that are specifically and explicitly inclusive and accessible, like community centers that foster inclusivity and are free to access or shopping places that are physically accessible, the participants shared that the lack of stigma made it comfortable enough for them to detach themselves from the coping mechanisms that were important to use in more stigmatizing spaces. Unlike Pathak et al.'s (2017) understanding of stoic ideology, the version of stoicism present in this study was less comprehensive than the all-encompassing stoicism that is commonly understood

in health-based research. Using a stoic lens in sociological research highlights the nuance of coping mechanisms that is vital in understanding how to create anti-stigmatizing policy and procedures in healthcare and academia.

Recommendations for Policy and Practice

In order to address the inequalities that low-income, higher-weight individuals face in healthcare and society in general, it is important to understand how they cope with these barriers. Through stoicism, participants often coped as individuals, personalizing their perceived failures rather than addressing the systemic biases and public discourses that reinforce the inequalities they face. The public and private infrastructure in New Brunswick is not designed to be accessible to low-income, higher-weight individuals, which, according to the literature and this research project, is a form of institutionalized stigma (Link & Phelan, 2001). Public transit is not prioritized, stifling low-income individuals' autonomy and mobility within their cities and around the province. Healthcare institutions, regardless of their socialized nature, often prioritize care for higher-income, stably employed individuals as access to services are provided through employee insurance and higher-income individuals have more ability to take time off to care for their wellness. This is due to the neoliberal ideals that inform how healthcare institutions are developed and accessed. For neoliberals, it is entirely reasonable that low-income individuals receive inadequate care due to their belief that low-income individuals have not worked hard enough to seize the "equal opportunities" that are presented to them in a capitalist system (McGregor, 2001). It is imperative that New Brunswick begins to prioritize marginalized people's healthcare and accessibility across

the province. The findings of this research have made it clear that accessibility intersects with various public policies including healthcare, education, and public transit. Without a comprehensive plan to address stigma in healthcare and in society weight- and income-based stigma will proliferate our public policies and discourses.

Participants shared some of their recommendations for making New Brunswick more welcoming, accessible, and safe for every citizen. Better education surrounding weight and class biases, including additional training resources for healthcare professionals and education on how to provide non-stigmatizing care, was one of the most prominent recommendations. Pausé (2014) details some recommendations on how to ensure non-stigmatizing practices are followed when providing care for fat patients stating that:

> doctors need to be encouraged to practice evidenced based healthcare, and not make decisions based on BMI; treat the person, and the ailment, not the body size. They need to be allowed the time to read academic journals that publish the latest health research, and provide information on how to best care for fat bodies (p. 139).

Pausé (2014) also explains how improving the physical spaces of healthcare environments can be more accessible and welcoming through the inclusion of fat friendly furniture, gowns, and diagnostic machines/tools in addition to fat friendly messaging in waiting rooms and in magazines. In addition, structural solutions like improving access to food security, affordable housing, Pharmacare, and accessible transit were all suggested by the participants. A comprehensive and multi-level approach is necessary to improve the resources and access to services for disadvantaged individuals in the province.

Limitations & Future Research

This research project used data that were collected for the Weight Stigma and Health Inequities in New Brunswick Marginalized Communities study led by Dr. Bombak. Due to this, the data collected focused on addressing research questions that were not specific to stigma management or stoicism in healthcare experiences. The small and unique sample included in this research is not able to be generalized beyond this sample. Future research should be conducted with larger samples that address stoicism as a coping mechanism for stigma specifically. Additionally, this research piloted the use of the PAQ-R as a qualitative analysis tool. More research should be conducted to assess its efficiency outside of this study sample.

CHAPTER 6: CONCLUSION

This research sought to assess the development of a stoic ideology in healthcare experiences as a way to cope with weight and income stigma. What I found was that the adoption of a stoic ideology is far more complex and nuanced than is accounted for by biomedical research. From a social science perspective, a stoic ideology is too deterministic and does not account for the everyday realities of the participants in this research study. Stoic behaviours can be developed and deployed variously in healthcare experiences and in daily life. Contrary to Pathak et al.'s (2017) conception of a stoic ideology, these behaviours are not all or nothing. At times, participants inadvertently used stoic behaviours to cope when it was necessary, but they were also able to shed their stoicism when they were not in stigmatizing situations.

Additionally, this research sought to understand stoicism through the lens of stigma management, but it became evident through data analysis and interpretation that stoic behaviours can also be used to cope with systemic barriers, particularly ones that are related to income inequality. Due to the integration of capitalist and neoliberal ideals in the healthcare system and public health messaging, participants interpellated structural barriers and often talked about their personal failings as challenges rather than the systemic disadvantaging of low-income individuals in society. Using stoic behaviours to cope with systemic barriers allowed participants to distance themselves from the negative emotions associated with the personal failings that neoliberalism espouses in health messaging. Often, this led participants to self-stigmatize, proving how pervasive these discourses are. The uptake of capitalist ideals, that everyone can advance socioeconomically if they try hard enough, mixed with fatphobic discourses of needing to

diet and exercise to lose weight and be a functioning member of society, clearly has major implications on the coping mechanisms of the participants.

Through the ongoing interpellation of healthist messaging surrounding income and fatphobic discourses mixed with stigmatization from others and from the self, participants developed stoic coping mechanisms to distance themselves from the strong negative emotions. Understanding how stoicism can be developed and deployed as separate behaviours rather than as a complete ideology can help inform future care practices among healthcare professionals. Stoicism is not limited to a pain-related coping mechanism, nor is it unique to the populations that have been studied thus far. Stoicism is pervasive and can mask major health concerns, triggering future health and social complications. Its prevalence among higher weight, low-income New Brunswickers cannot be ignored in future social science and health research. This study can serve as a foundation for understanding how participants deploy individual stoic behaviours, both separately and in conjunction with other stoic behaviours as a diverse and unique population.

REFERENCES

Adler, N. E., Glymour, M. M., & Fielding, J. (2016). Addressing social determinants of health and health inequalities. *Jama*, *316*(16), 1641-1642.

Alberga, A. S., Edache, I. Y., Forhan, M., & Russell-Mayhew, S. (2019). Weight bias and health care utilization: a scoping review. *Primary health care research & development*, *20*.

Althusser, L. (2010). Ideology and ideological state apparatuses (notes towards an investigation) (1970). *Cultural theory: an Anthology*, 204-22.

Amy, N. K., Aalborg, A., Lyons, P., & Keranen, L. (2006). Barriers to routine gynecological cancer screening for White and African-American obese women. *International journal of obesity*, *30*(1), 147-155.

Arber, A. (2004). Is pain what the patient says it is? interpreting an account of pain. *International Journal of Palliative Nursing*, *10*(10), 491–496. https://doi.org/10.12968/ijpn.2004.10.10.16214

Bacon, L., & Aphramor, L. (2011). Weight science: Evaluating the evidence for a paradigm shift. *Nutrition Journal, 10*(1), 1-13.

Bambra, C., Gibson, M., Sowden, A., Wright, K., Whitehead, M., & Petticrew, M. (2010). Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews. *Journal of Epidemiology & Community Health*, *64*(4), 284-291.

Bericat, E. (2016). The sociology of emotions: Four decades of progress. *Current Sociology*, *64*(3), 491-513.

Blumer, H. (1969). The methodological position of symbolic interactionism. In *Symbolic interactionism: Perspective and method* (pp. 1-60). Berkeley: University of California Press.

Bombak, AE. 2014. Obesity, Health-at-Every-Size, and public health policy. *American Journal of Public Health* 104(2): e60–e67. doi:10.2105/AJPH.2013.301486.

Bombak, A., McPhail, D., & Ward, P. (2016). Reproducing stigma: Interpreting "overweight" and "obese" women's experiences of weight-based discrimination in reproductive healthcare. *Social Science & Medicine, 166*, 94-101. doi:10.1016/j.socscimed.2016.08.015

Bombak AE, Meadows A, Billette J. (2019). Fat Acceptance 101: Perceptions of cultural body acceptance among higher-weight women in America's Midwest. *Health Sociology Review 28*(2), 194-208.

Bosomworth, N. J. (2012). The downside of weight loss: Realistic intervention in body-weight trajectory. *Canadian Family Physician*, *58*(5), 517–523.

Bringer, J., Johnston, L., & Brackenridge, C. (2006). Using computer-assisted qualitative data analysis software to develop a grounded theory project. *Field Methods, 18*(3), 245-266.

Bryman, A. & Bell, E. (2019). *Social research methods* (5th Canadian ed.). Don Mills, Ont.: Oxford University Press.

Burke, P. J., & Tully, J. C. (1977). The measurement of role identity. *Social forces*, *55*(4), 881-897.

Cagle, J., & Bunting, M. (2017). Patient reluctance to discuss pain: understanding stoicism, stigma, and other contributing factors. *Journal of Social Work in End-O*

f-Life & Palliative Care, *13*(1), 27–43. https://doi.org/10.108 0/15524256.2017.128291

Canada, P. (2020, October 07). Government of Canada. Retrieved from https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html

Carastathis, A. (2014). The concept of intersectionality in feminist theory: the concept of intersectionality in feminist theory. *Philosophy Compass*, *9*(5), 304–314. https://doi.org/10.1111/phc3.12129

Casazza, K., Fontaine, K. R., Astrup, A., Birch, L. L., Brown, A. W., Bohan Brown, M. M., . . . Allison, D. B. (2013). Myths, Presumptions, and Facts about Obesity. *N Engl J Med, 368*(5), 446-454. doi:10.1056/NEJMsa1208051

Christensen, A. D., & Jensen, S. Q. (2012). Doing intersectional analysis: Methodological implications for qualitative research. *NORA-Nordic Journal of Feminist and Gender Research*, *20*(2), 109-125.

Colls, R., & Evans, B. (2014). Making space for fat bodies? Progress in Human Geography, 38(6), 733-753. doi:10.1177/0309132513500373

Cooper, C. (2010). Fat studies: Mapping the field. *Sociology Compass*, 4(12), 1020-1034.

Cooley, C. (1964). Society and the individual. In *Human nature and the social order* (Schocken paperbacks) (pp. 35-50). New York: Schocken Books.

Crawford, R. (1980). Healthism and the medicalization of everyday life. *International Journal of Health Services, 10*(3), 365-388.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *u. Chi. Legal f.*, 139.

Creswell, J. W., & Poth, C. N. (2007). *Qualitative inquiry and research design: Choosing among five approaches*. Sage publications.

Cuádraz, G. H., & Uttal, L. (1999). Intersectionality and in-depth interviews: Methodological strategies for analyzing race, class, and gender. *Race, Gender & Class*, 156-186.

Davies, D. (1998). Health and the discourse of weight control. In A. Peterson, & C. Waddell (Eds.), *A sociology of illness, prevention and care* (Buckinngham ed., pp. 141-155) Open University Press.

Davies, C. A. (2008). *Reflexive ethnography: A guide to researching selves and others*. Routledge. Chapter 3: Ethics and politics, pp. 45-64

Denscombe, M., (2012). Research ethics: Is the research socially acceptable? In Denscombe, *Research proposals: A practical guide* (pp. 121-136). The McGraw-Hill Companies.

Durso, L. E., & Latner, J. D. (2008). Understanding self-directed stigma: development of the weight bias internalization scale. *Obesity*, *16*(S2), S80-S86.

Emerson, R. M., Fretz, R. I., & Shaw, L. L. (2011). *Writing ethnographic fieldnotes*. University of Chicago Press.

Farrell, L. C., Warin, M. J., Moore, V. M., & Street, J. M. (2016). Socio-economic divergence in public opinions about preventive obesity regulations: Is the

purpose to ‘make some things cheaper, more affordable’or to ‘help them get over their own ignorance’?. *Social Science & Medicine*, *154*, 1-8.

First Nations Information Governance Centre. (2020). *OCAP.* Retrieved from https://fnigc.ca/ocap

Gard, M., & Wright, J. (2005). The obesity epidemic: Science, morality and ideology. Abingdon, Oxon: Routledge.

Geertz, C. (1973). Thick description: Toward an interpretive theory of culture. In The cultural geography reader (pp. 41-51). Routledge.

Gillsjö C., Nässén K., & Berglund, M. (2020). Suffering in silence: a qualitative study of older adults’ experiences of living with long-term musculoskeletal pain at home. *European Journal of Ageing*, *(20200416)*. https://doi.org/10.1007/s10433-020-00566-7

Godley, J., & McLaren, L. (2010). Socioeconomic status and body mass index in Canada: exploring measures and mechanisms. *Canadian Review of Sociology/Revue canadienne de sociologie*, *47*(4), 381-403.

Goffman, E. (1959). Introduction. In *The presentation of self in everyday life* (Penguin psychology) (pp. 1-16). London: Penguin.

Hebert, J. R., Allison, D. B., Archer, E., Lavie, C. J., & Blair, S. N. (2013). Scientific decision making, policy decisions, and the obesity pandemic. *Mayo Clinic Proceedings, 88*(6), 593-604. doi:10.1016/j.mayocp.2013.04.005

Himmelstein, M., PhD, Puhl, R., PhD, & Quinn, D., PhD. (2017). Intersectionality: An understudied framework for addressing weight stigma. *American Journal of Preventive Medicine, 53*(4), 421-431. doi:10.1016/j.amepre.2017.04.003

Kaba, R., Sooriakumaran, P. (2007). The evolution of the doctor-patient relationship. *International Journal of Surgery, 5*(1), 57-65.

Kaufman, J. M., & Johnson, C. (2004). Stigmatized individuals and the process of identity. *The Sociological Quarterly*, *45*(4), 807–833.

Khan, R., Apramian, T., Kang, J. H., Gustafson, J., & Sibbald, S. (2020). Demographic and socioeconomic characteristics of Canadian medical students: a cross-sectional study. *BMC medical education*, *20*, 1-8.

Kiger, M. E., & Varpio, L. (2020). Thematic analysis of qualitative data: AMEE Guide No. 131. *Medical Teacher, 42*(8), 846-854.

Kirkland, A. (2011). The environmental account of obesity: A case for feminist skepticism. *Signs, 36*(2), 463-485.

Latimer, M., Young, S., Dell, C., & Finley, G. A. (2012). Aboriginal children and physical pain: what do we know?. *International Journal of Indigenous Health*, *9*(1), 7-14.

Latimer, M., Finley, G. A., Rudderham, S., Inglis, S., Francis, J., Young, S., & Hutt-MacLeod, D. (2014). Expression of pain among Mi'kmaq children in one Atlantic Canadian community: a qualitative study. CMAJ open, 2(3), E133–E138. doi:10.9778/cmajo.20130086

Lavallee, D. C., Chenok, K. E., Love, R. M., Petersen, C., Holve, E., Segal, C. D., & Franklin, P. D. (2016). Incorporating patient-reported outcomes into health care to engage patients and enhance care. *Health Affairs*, *35*(4), 575-582.

Lazare, A. (1987). Shame and humiliation in the medical encounter. *Archives of internal medicine*, *147*(9), 1653-1658.

LeCompte, M. D., & Schensul, J. J. (2010). *Designing and conducting ethnographic research: An introduction* (Vol. 1). Rowman Altamira.

Legard, R., Keegan, J., & Ward, K. (2003). In-Depth Interviews. In Ritchie, J. & Lewis, J., *Qualitative research practice: A guide for social science students and researchers* (138-169). London: SAGE Publications.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*(1), 363–385. https://doi.org/10.1146/annurev.soc.27.1.363

Low, J. (2016). *Symbolic interactionism and health*. [PowerPoint slides].

Mann, J. P., Jakes, A. D., Hayden, J. D., & Barth, J. H. (2015). Systematic review of definitions of failure in revisional bariatric surgery. *Obesity Surgery*, *25*, 571–574. https://doi.org/ 10.1007/s11695-014- 1541-2

McGregor, S. (2001). Neoliberalism and health care. *International Journal of Consumer Studies*, *25*(2), 82-89.

McLaren, L., Godley, J., & MacNairn, I. A. (2009). Social class, gender, and time use: implications for the social determinants of body weight?. *Health reports*, *20*(4), 65.

Mead, G., & Morris, C. (1967). The self. In *Mind, self, and society: From the standpoint of a social behaviorist* (Phoenix books) (C. Morris, Ed.) (pp. 135-226). Chicago, Ill: University of Chicago Press.

Meadows, K. A. (2003). So you want to do research? 2: developing the research question. *British Journal of Community Nursing*, *8*(9), 397-403.

Mensinger, J. L., Tylka, T. L., & Calamari, M. E. (2018). Mechanisms underlying weight status and healthcare avoidance in women: A study of weight stigma, body-related shame and guilt, and healthcare stress. *Body Image*, *25*, 139-147.

Merriam-Webster. (n.d.). Save face. In *Merriam-Webster.com dictionary*. Retrieved August 6, 2021, from https://www.merriam-webster.com/dictionary/save%20face

Monaghan, L. F., & Hardey, M. (2009). Bodily sensibility: Vocabularies of the discredited male body. *Critical Public Health, 19*(3-4), 341-362.

Moore, A., Grime, J., Campbell, P., & Richardson, J. (2013). Troubling stoicism: sociocultural influences and applications to health and illness behaviour. *Health (London, England : 1997)*, *17*(2), 159–73. https://doi.org/10.117 7/1363459312451179

Murray, S. (2008). Normative imperatives vs pathological bodies: Constructing the 'fat'woman. *Australian Feminist Studies*, *23*(56), 213-224.

Nichter, M. (2000). *Fat talk : what girls and their parents say about dieting*. Harvard University Press.

Pathak E. B., Wieten S. E., Wheldon C.W. (2017). Stoic beliefs and health: development and preliminary validation of the Pathak-Wieten Stoicism Ideology Scale. *BMJ Open* 2017;**7:**e015137. doi:10.1136/bmjopen-2016-015137

Pausé, C. (2014). Die another day: the obstacles facing fat people in accessing quality healthcare. *Narrative inquiry in bioethics*, *4*(2), 135-141.

Public Health Agency of Canada. (2019, July 25). Government of Canada. Retrieved from https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html.

Puhl, R. M., & Heuer, C. A. (2010). Obesity stigma: Important considerations for public health. American Journal of Public Health, 100(6), 1019-1028. Retrieved from http://www.scopus.com/inward/record.url?eid=2-s2.0-77952251104&partnerID=40&md5=da659837ad2e26c655cf55fa23b65088

Riediger, N. D., Kingson, O., Mudryj, A., Farquhar, K. L., Spence, K. A., Vagianos, K., & Suh, M. (2018). Diversity and equity in dietetics and undergraduate nutrition education in Manitoba. *Canadian Journal of Dietetic practice and research*, *80*(1), 44-46.

Ruckert, A., Huynh, C., & Labonté, R. (2018). Reducing health inequities: is universal basic income the way forward?. *Journal of Public Health*, *40*(1), 3-7.

Ryan, G. W. and Bernard, H. R. (2003). Techniques to identify themes. *Field Methods*, 15(1):85-109.

Schrecker, T. (2016). Neoliberalism and health: the linkages and the dangers. *Sociology Compass*, *10*(10), 952-971.

Schwartz, M. B., Chambliss, H. O. N., Brownell, K. D., Blair, S. N., & Billington, C. (2003). Weight bias among health professionals specializing in obesity. *Obesity research*, *11*(9), 1033-1039.

Thille, P. (2019). Managing Anti-Fat Stigma in Primary Care: An Observational Study, Health Communication, 34:8, 892-903, DOI: 10.1080/10410236.2018.1439276

Thomson, G., Ebisch-Burton, K., & Flacking, R. (2015). Shame if you do--shame if you don't: women's experiences of infant feeding. *Matern Child Nutr, 11*(1), 33-46. doi:10.1111/mcn.12148

Turner, J. H., & Stets, J. E. (2006). Sociological theories of human emotions. *Annu. Rev. Sociol.*, *32*, 25-52.

Warin, M. (2011). Foucault's progeny: Jamie Oliver and the art of governing obesity. *Social Theory & Health, 9*(1), 24-40.

Weitz, R. (2016). *The sociology of health, illness, and health care: A critical approach*. Cengage learning.

Welsh, T. (2011). Healthism and the bodies of women: Pleasure and discipline in the war against obesity. *Journal of Feminist Scholarship, 1*(Fall 2011), 33-48.

Wharton, S., Lau, D. C. W., Vallis, M., Sharma, A. M., Biertho, L., Campbell-Scherer, D., . . . Wicklum, S. (2020). Obesity in adults: a clinical practice guideline. *Canadian Medical Association Journal, 192*(31), E875. doi:10.1503/cmaj.191707

Windsong, E. A. (2016). Incorporating intersectionality into research design: An example using qualitative interviews. *International Journal of Social Research Methodology*, *21*(2), 135-147.

Woods, A. (2016, January 14). *What is historical materialism?* In defense of Marxism. https://www.marxist.com/an-introduction-to-historical-materialism/all-pages.htm

World Health Organization. (2010, December 1). The determinants of health. Retrieved from https://www.who.int/hia/evidence/doh/en/.

Yong, H. H., Gibson, S. J., de L. Horne, D. J., & Helme, R. D. (2001). Development of a pain attitudes questionnaire to assess stoicism and cautiousness for possible age differences. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *56*(5), P279-P284.

Yong, H. H., Bell, R., Workman, B., & Gibson, S. J. (2003). Psychometric properties of the Pain Attitudes Questionnaire (revised) in adult patients with chronic pain. *Pain*, *104*(3), 673-681.

Yong, H.-H. (2006). Can attitudes of stoicism and cautiousness explain observed age-related variation in levels of self-rated pain, mood disturbance and functional interference in chronic pain patients? *European Journal of Pain*, *10*(5), 399–407. https://doi.org/10.1016/j.ejpain.2005.05.004

APPENDIX A: PARTICIPANT DESCRIPTIONS

Table 2: Description of Participants

Participant Pseudonym	Brief Description
Angela	A white, cis woman living and working in rural New Brunswick.
Avery	A white, cis woman studying and working in urban New Brunswick.
Elizabeth	A white, cis woman attending university in urban New Brunswick.
Elouise	A white, cis woman with a chronic disability living in urban New Brunswick.
Isabelle	A white, cis woman working and attending school in urban New Brunswick.
Jordan	A white, non-binary person living in urban New Brunswick.
Judith	A white, cis woman with a chronic illness living in urban New Brunswick.
Miriam	A white, cis woman with a chronic disability living in urban New Brunswick.
Penelope	A black, cis woman working and living in urban New Brunswick.
Ryan	A white, cis man living and working in urban New Brunswick.
Trevor	A white, cis man living with a chronic mental illness in urban New Brunswick

CURRICULUM VITAE

Candidate's full name: Alison Turner

Universities attended (with dates and degrees obtained):

Bachelor of Philosophy in Interdisciplinary Leadership Studies, University of New Brunswick, 2019

Publications:

Brownell, A., Dale, S. Dube, C., Fernandez, C., Jardone, C., Hamilton, O., … **Turner, A.,**… Zundel, E. (2017). The mirror of Erised: Seeing a better world through Harry Potter and Critical Theory. UNB Scholar.

Conference Presentations:

Bombak, A.E., **Turner, A.,** Chinho, N., Thomson, L., Burk, C., Sheehan, J. Intersections of Weight Stigma in New Brunswick Marginalized Communities. International Weight Stigma Conference, Auckland, New Zealand, June 22-23, 2020 (Conference cancelled).

Bombak, A.E., **Turner, A.,** Chinho, N., Thomson, L., Burk, C., Sheehan, J. Intersectional Weight Stigma and Coping Mechanisms Among Marginalized Groups in New Brunswick. Canadian Public Health Association Public Health 2020, Winnipeg, MB, April 28-30, 2020 (Conference postponed).

Sheehan, J., **Turner, A**., Bombak, A.E. Weight Stigma and Health Inequities in New Brunswick's Marginalized Communities [Poster session cancelled-presenter emergency]. 48th Annual Scientific and Educational Meeting of the Canadian Association on Gerontology, Moncton, NB, Oct. 24-25, 2019 (poster).

Sheehan, J., **Turner, A.**, Bombak, A.E. Weight Stigma and Health Inequities in New Brunswick's Marginalized Communities. New Brunswick Health Research Foundation Conference. St John, NB, Nov. 6-7, 2019 (poster).