Mothering Out of Bounds: Inequality and Resistance in Fat Motherhood

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ABSTRACT

What happens when “child bearing hips” become ‘too’ wide and layered with fat? The medicalization of weight and body size pathologizes difference as deviance, framing fat women as a danger not only to themselves but to society at large when daring to reproduce. This dissertation seeks to uncover the long term impacts of weight stigma at different intersections in order to expand sociological understandings of fatness, health, gender, and inequality in motherhood. It highlights parallel mechanisms of surveillance (for example, between fat and poor mothers) to show how society constructs who “should” and “should not” be parents. Based on a series of 36 in-depth interviews with 18 mothers conducted in the first half of 2022, findings illustrate that the negative social and medical perception of fat motherhood has a significant detrimental impact on the lived experiences of fat mothers. Findings also pull from material culture in the form of representational artifacts from motherhood brought by participants in order to understand how medical and social anti-fatness impacts identity and experiences, and contributes to inequality in fat motherhood.

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GENERAL AUDIENCE ABSTRACT

What happens when “child bearing hips” become ‘too’ wide and layered with fat? The medicalization of weight and body size pathologizes difference as deviance, framing fat women as a danger not only to themselves but to society at large when daring to reproduce. This dissertation seeks to uncover the long term impacts of weight stigma at different intersections in order to expand sociological understandings of fatness, health, gender, and inequality in motherhood. It highlights parallel mechanisms of surveillance to show how society constructs who “should” and “should not” be parents. Based on a series of 36 in-depth interviews with 18 mothers conducted in the first half of 2022, findings illustrate that the negative social and medical perception of fat motherhood has a significant detrimental impact on the lived experiences of fat mothers. Mothers were also invited to bring objects that were of importance to them to discuss the ways in which society's negative views about weight impacted their experience.

DEDICATION

This dissertation is dedicated to my mom, Sara Roeper, and to my grandmother, Sally Shovar, who have been the guiding lights throughout my life.

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I extend my deepest appreciation to the mothers that shared their stories with us. I am honored to have the privilege of sharing them within this text. I am grateful for their time, effort, and candid reflections and for everything they taught me.

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CHAPTER 1: INTRODUCTION

For decades, though most explosively in the last 30 years, discourse about "obesity," fatness, and bodies has circulated between the field of public health and popular media (Warin et. al 2016; Brown 2015; Rail et al. 2010). I utilize Michel Foucault's (1980) conceptualization of discourse as a constructed dissemination of knowledge production that is never neutral or objective, but rather pointed and intertwined with power relations. Indeed, as Waggoner (2017) points out, "what has become conventional medical and health wisdom is intricately tied up with what is considered conventional social wisdom" (23). Anti-fat discourse has fueled a 'war on obesity' and an obesity studies field. The war on obesity can be understood as a wide reaching campaign of policies and programs that problematize body fat and create 'solutions' to fatness (O'Hara and Gregg 2006). Obesity studies is largely housed in medical, public health, and nutrition academic disciplines and frames weight as a concern that requires medical oversight and intervention (O'Hara and Gregg 2006). The search for a thin cure has moved the frontlines of the 'war on obesity' to those responsible for producing potentially fat children: fat mothers (Xu et al. 2014).

Medical shaming discourse of fat pregnant people has been shown to have wide ranging negative impacts, influencing everything from mothers' experiences of pregnancy to their identity as parents (Parker and Pausé 2018). A lifetime of stigmatizing social interactions adds up to significant negative psychological outcomes for fat folks (Seruya 2020). Further, the ways in which fatness is framed in discourse impact how modern motherhood is shaped (Davidson and Lewin 2018). Research has shown that simply anticipating a fatphobic experience or confrontation takes a physical and mental toll on fat folks (Seruya 2020). Fat folks experience chronic trauma as a result of systemic weight stigma, which is defined as the fear and disgust of

fatness (Robinson et al. 1993). Further, systemic weight stigma refers to discrimination against a person based on stereotypes framing fat people as out of control, lazy, and a burden on society (Chrisler and Barney 2017; Pausé 2017). This is carried out through many channels: via the body, personally, interpersonally, and structurally (Chrisler and Barney 2017) and permeates most life experiences, including parenting and reproduction. However, anti-fatness does not operate alone. Previous research has shown the ways weight stigma intersects with racism, classism, and ableism resulting in a range of negative outcomes related to fatness and parenthood further (LaMarre et al. 2020). Weight stigma results in a lifelong accrual of disadvantage and inequality, which is compounded in reproductive settings via exclusion, increased surveillance, and the framing of fat women as bad mothers (Rogge et al. 2004; Huelsman 2012). In order to combat this "war on obesity," a recent influx of research investigating fatness and reproductive justice that situates weight stigma as a reproductive justice issue emerged.

Work on fatness and reproduction is being conducted in fields such as midwifery (Daniel 2007), clinical nutrition (Bonakdar et al. 2019), and psychology (Puhl et al. 2021), but it is most often conducted through an anti-obesity lens. The majority of work being done at the intersections of reproductive justice, mothering, and fat studies focuses on pregnancy and prenatal care (Neiterman 2013; Parker and Pausé 2018; Kelley et al. 2019; Jette and Rail 2004). This work is crucial, and arguably has the potential to make fat parenthood more accessible, equitable, and safe for both the parent and child. As my dissertation is firmly fat positive,[1] I do not align my work with obesity studies. Rather, as a sociologist and fat studies scholar my work investigates the inequality associated with the long-term impact weight stigma has on mothers

[1] Fat positivity comes from the fat liberation movement and refers to understanding fat bodies as deserving of respect, worthy of love and joy, and equal treatment (Simic 2016).

beyond pregnancy. Thus, my work explores how weight stigma in everyday interactions may produce long-term effects on fat mothers from preconception to motherhood.

Importantly, the 'war on obesity' shifted to include a *preemptive* war on *potential* fat people, which includes mothers and children (Parker and Pause 2018; Rich and Evans, 2005). Indeed, significant barriers exist to preclude fat women who want to become pregnant or have children (LaMarre et al. 2020). These barriers exist in a myriad of institutions, including the legal system and the medical industrial complex–described as a transition from individual doctors and hospitals to national businesses and medical empires (Ehrenreich and Ehrenreich 1971). The United States is continually building a society that intentionally excludes fat people from parenting–a type of oppression that is justified under anticipation of disaster in the form of monstrous adiposity. In an attempt to evade adiposity, exclusions range from body mass index[2] (BMI) limits in IVF treatments (Turner-McGrievy and Grant 2015) to the legality of deciding custody arrangements based on a parent's weight (Dissell 2011 and Badshah 2021). Ultimately, these social structures and institutions create neo-eugenicist barriers that limit fat women's ability to participate in parenthood through discipline and anticipatory regimes.

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[2] The body mass index was created over 200 years ago by Adolphe Quetelet, an academic interested in measuring 'the average man" (Your Fat Friend 2019). This formula was made by and for white people in Western Europe but was never meant to measure any one individual's health, body fat, or build–a caveat underlined by Quetelet himself. However, this formula was quickly circulated as a means to justify eugenics (a measurement of a person's fitness to parent) and standards of beauty by the early twentieth century (Grue and Heiberg 2006). Not only was this formula not meant to measure individuals, but only white men were considered in its creation. In 1995, the World Health Organization warned that the BMI was not an accurate way to measure 'obesity', but changed their stance by 1998 (Saguy 2013). In the last 20 years, scientists have shown that Black people tend to have higher muscle mass and mineral bone density than white people do, which increases BMI (Strings 2019). The problems with the BMI are also gendered (Rahman and Berenson 2011). White women have higher mortality rates than Black women do at the same BMI- but for Black women, their size is a marker of disease, fear, and anxiety (Strings 2019). The BMI is a quick, free measurement for doctors and insurance agents to run, but it comes at a high cost that most significantly impacts fat Black women. It is an inaccurate measurement at best and actively contributing to health disparities at worst.

Anticipatory regimes are social structures, institutions, and practices that are designed to prepare individuals or groups for future events or changes, often with obligatory proactiveness (Adams, Murphy, and Clarke 2009). These regimes are based on the idea that individuals or groups need to be prepared for various possible scenarios in order to adapt to and thrive in changing circumstances while minimizing risk (Adams et al. 2009; Ballif 2022; Waggoner 2017). Anticipatory regimes can take many forms, such as educational programs, disaster preparedness planning or health promotion campaigns, and can be initiated by various actors, such as governments, businesses, or educational institutions. Anticipatory regimes may also be driven by different motives, such as economic competitiveness, environmental sustainability, or eugenics. Anticipatory regimes may also generate new forms of inequality, exclusion, or conflict, as different groups have unequal access to the resources and opportunities needed to prepare for the future (Waggoner 2017). Further, they are often "highly biomedical and gendered. When it comes to the next generation's health, the vector of anticipatory risk is often a woman" (Waggoner 2017: 25). Anticipatory regimes work to push the belief that it is both possible and important to shape the future through deliberate actions and investments, rather than simply reacting to events as they unfold.

Sociologists of the family have theorized the discursive and influential power of anticipatory regimes to shape how people experience pregnancy and parenthood (Ballif 2022). Discursive power positions people as either good or bad citizens in relation to the state. Adams et al. (2009) extend this theoretical framework of anticipation to appreciate the importance of good citizenship on the future health of the state through reproduction. Not only is it important to be a good citizen, but it is important to continue the future of good citizenship through parenthood. Waggoner (2017) explains the ways "future motherhood" has created a new industry in

"pre-pregnancy" (2-3). Good citizenship is intergenerational and thus there is a social responsibility to continue this work in reproduction and parenting (Adams et al. 2009). In the United States, the values of risk aversion and individual responsibility for health are exemplified in the way people anticipate and attempt to reduce potential future risks related to reproduction (Waggoner 2017). Anti-fat stigma prohibits fat women from good citizenship both on the basis of their own personhood and their ability to create and raise good citizens.

"Good"ness, then, extends into fat women's experience of motherhood. Specifically, the experience of motherhood is deeply entwined with issues of power and identity–with power dynamics often manifesting within the physical and emotional experiences of motherhood. Moreover, the complexities of motherhood are further complicated by the impact of body size and fatness, which can shape and influence the ways in which women experience and negotiate their maternal identities. As Shields (2008) points out, identity "reflects the operation of power relationships among groups that compromise that identity category" (302). For women, power relations are "played out within the embodied experience of motherhood" (Einion and Rinaldi 2018: 26). These power relations are complicated by fatness. Indeed, Parker and Pause (2018) point out that while there is a plethora of work that attempts to frame fat motherhood as a dangerous health crisis, there is a total exclusion of fat mothers themselves in the discourse. I therefore center fat mothers' voices (including mothers who did not give birth to their children) in this interview-focused research project as a way to capture their experiences of weight stigma as they relate to the full experience of motherhood from conception to after having children.

In doing so, I draw parallels between mechanisms of surveillance to show how society constructs who should and should not be parents. This research focuses on weight stigma and its impact on fat mothers in the United States. By examining this specific issue, I aim to gain insight

into the larger question of who is considered "deserving" of being a parent in contemporary US society. This continues work being done to understand how regulating fat pregnancy amplifies existing raced and classed biases in reproductive care (Parker and Pausé 2018).

My research seeks to uncover the ways in which fat people are perceived to be unable to create and provide safe and healthy environments–especially for their children. I do so by exploring the following research questions:

1. How does weight stigma affect fat women in their role as mothers?
    a. How does this generate inequality for fat mothers, their children, and their families?
    b. How are fat women navigating anti-fat environments?
2. How does anticipation of the future impact fat mothers?
3. In what ways does formally talking about fatness and anti-fatness encourage fat mothers to reevaluate their experiences?

CHAPTER 2: LITERATURE REVIEW

Introduction

In order to be a mother, one must first become a mother. The process of becoming a mother has the potential to shape a person's experience of motherhood (Einion and Rinaldi 2018). In this chapter, I first provide a theoretical foundation by unpacking theories of anticipation and motherhood. Next, a section on gender explores how fatness and motherhood are co-engendered by anti-fat discourse. I then provide a brief historical overview of the racial origins of anti-fat bias and weight-based stigmatization. After reviewing the ways in which body size has been medicalized and brought into medical purview, I detail several examples of weight-based discrimination throughout the entire process of becoming a mother–which includes conception, pregnancy, adoption, and parenting. This chapter concludes by underlining the gaps in current research on weight and motherhood.

Theoretical Foundations

Mothering cannot be defined or understood as a single or static experience and there is no single feminist position on motherhood (McMahon 1995; Lane and Joensuu 2018). Lane and Joensuu (2018) take this one step further by deciding not to define mothering as such definitions "limit and constrain" rather than make room for ambiguity (7). Mothers are socially located by class, age, race, sexuality, size, ability, and beyond. In these intersecting locations the experience and the meaning of mothering are shaped. Maternal bodies are often discussed in tandem with a gendered reproductive lens (Einion and Rinaldi 2018). In this study "mother" extends beyond a sexed binary to include mothers who may not identify as women or who may not have been assigned female at birth. I also include mothers who did not give birth to their children and who

may not be biologically related to the children they mother. Sociologists of the family use the term social mothers to describe the relationship between a mother who is caring for children she is not biologically related to, while biological mothers are related to the children they mother (Carlson and England 2011). Patton-Imani (2020) discusses how the term "birth mother" is malleable, indicating both legitimate and illegitimate mothers depending on the context (13). Specifically, she notes that "birth mother" in "lesbian-headed families" means that the birth mother is the "legitimate mother"; whereas in adoptions, "birth mother" indicates an illegitimate mother who is "*not-the-mother"* (Patton-Imani 2020: 13). For the purposes of this study, a mother is someone who identifies as such.

Scholars have defined motherhood in a variety of ways, though each has come under critique for offering too narrow of a definition. In her seminal piece, *Of woman born: Motherhood as experience and institution*, Adrienne Rich (1976: 13) theorized motherhood as a "patriarchal institution… that is male-defined and controlled and is deeply oppressive to women, while the word 'mothering' refers to women's experiences of mothering that are female-defined and centered and potentially empowering to women."In other words, "motherhood" is an institution and "mothering" is a practice. McMahon (1995) argues that the theoretical divide between the *work* of mothering and the *relationship* of mothering has been studied in a way that often ends in a focus on women's oppression that disallows room for agency and joy. The work of mothering that McMahon (1995) refers to is the everyday tasks of caring for children; whereas the relationship of mothering represents both the relationship mothers have with their child(ren) and themselves. She expands this idea further by arguing that even in using 'motherhood' as a singular term we misrepresent a variable relationship that is constantly in flux, impacted by society and history. bell hooks (2021) points out that women of color and poor women were

largely alienated when early feminist movements attacked motherhood. A focus on motherhood as a primarily oppressive role reinforces a limited view of women's reproductive choices and the idea that women who choose to become mothers are somehow complicit in their own oppression. It suggests that motherhood is a burden that women should avoid or resist, rather than a choice that can be empowering and fulfilling. On the other hand, it is dangerous to romanticize motherhood as this leans into the notion that women who do not mother can never fulfill their true purpose (hooks 2021). While socially taboo and rarely discussed, some mothers regret becoming mothers at all resulting in "tensions and ambivalence…helplessness, frustration, guilt, shame, anger, hostility, and disappointment" (Donath 2017:xiv). Many of the mothers McMahon (1995) interviewed did not transition seamlessly into motherhood and instead found the path "tentative, unanticipated, unfamiliar, and beset with problems" (265). Motherhood, then, is political beyond reproductive choice (McMahon 1995; Lane and Joensuu 2018).

How might anticipation influence motherhood? Sociologist Edmée Ballif (2022) argues that we must consider the experience of becoming a mother from conception through the child's existence, as a through line connected by anticipation. Anticipation of the future impacts how we feel, conceptualize, and deal with both our current and potential future situations (Adams et al. 2009). Through anticipation, we are existing in both the current moment and also projecting into a possible future. Historically, motherhood and anticipation have been linked. Motherhood has been viewed as a deeply moral position, with mothers "defined as the moral guardians of western civilisation with the immediate responsibility for children's character development and ultimate responsibility for the moral texture of public life" (Maroney 1986: 42). More specifically, motherhood has been linked to both capitalism and colonialism, tying oneself to both the past and present of not only their immediate family but to their nation. For Ballif (2022), "analyzing

anticipatory regimes contributes to discussions of power relations in…reproduction and challenges to reproductive justice" (1). A key component of understanding anticipatory regimes is the centrality of risk in mothering and motherhood (Hays 1996; Waggoner 2017). Fetuses, infants, and children are considered vulnerable and must be protected by their parents who bear the burden of "monitoring and enabling the best possible outcomes for their children"--which most of this responsibility falls to mothers (Ballif 2022: 3). Having children at all, Ballif argues, links you with the future. Further, the anticipated future is deeply linked with representations of white, middle-class, heteronormative and nuclear family models unattainable for most (Ballif 2022; Waggoner 2017). Structural anticipatory regimes operate on a macro level but individuals engage in self-surveillance and self-discipline via body/appearance work as a result.

Within sociology of the body, Gimlin (2007) argues 'body work' can be understood as four main categories: "body/appearance work, body work/labor[3], body/emotion management[4], body-making through work[5]" (353). The current study is primarily concerned with body work in the first form, to describe the work we do on our own bodies to fit within specific cultural constraints (Gimlin 2007). This body work ranges from bathing to plastic surgery (Twigg 2000). In the United States, women are especially pressured to spend more time and money doing this kind of work (Twigg 2000). This pressure is compounded by race and size, where fat women of color are compelled to engage in higher levels of body work than thin or fat white women.

Anticipation has fueled a boom in biomedicine wherein death is a "technical prediction of not when death has arrived, but rather of one's ability to bring time of death to present

[3] This form of body work is concerned with work performed on other people's bodies, an example of which is health care providers (Gimlin 2007).
[4] This third form of body work covers emotional management and performing emotions at work (Gimlin 2007; Hoschild 2012).
[5] This is the study of how bodies are impacted by the work they do (Gimlin 2007).

decision-making about care" (Adams et al. 2009: 251). Anticipation in biosecurity creates consumer markets for health related potential future disasters. While this is not always negative, it is important to understand how anticipation is used to further capitalist goals under the guise of preparedness. Adams et al. (2009) write that "anticipatory regimes reconfigure populations as evidence for rising epidemics of everything from infertility to attention deficit disorder" (252-253). An example of this is doctors promoting weight loss surgery for fat women prior to offering assisted reproductive technology. This then generates more profits for the medical industrial complex as some women may take this drastic measure in order to fulfill their dreams of (potentially) becoming mothers. Thus, anticipation impacts all stages of reproduction and parenting in both individual and systemic ways (Waggoner 2017).

In order to understand the different ways anticipation functions, Adams et al. (2009) broke anticipation into five subcategories: injunction, abduction, optimization, preparation, and possibility. In relation to anticipation, injunction can be understood as a *moral* obligation to remain aware of potential futures. In order to be a good citizen one must be vigilant at all times. Abduction can be defined as the ways in which we decide what to do about anticipated futures through 'what-if' scenarios. For example, a mother might consider what would happen if she returns to work, compared to the 'what if' of being a stay at home mom, in order to anticipate the best possible scenario for her child. Optimization requires each individual to maximize their chance at the best possible future–which is a lifelong process. Preparation is the goal of being ready for an event as if it were taking place in the current moment. And, possibility as a subcategory of anticipation, functions as hope. All five of these subcategories of anticipation are related to the present study on weight and motherhood.

Gender

Weight and gender interact, as fatness blurs conventional gender performances of femininity and masculinity (Bell and McNaughton 2007). As weight increases, social norms dictate that gender performance must also be exaggerated. Gender performance, or performative femininity, was described by Judith Butler (1988) to underline how doing gender is not instinctual, but rather a combination of everyday behaviors performed privately and publicly typically without conscious thought or intention. Motherhood and mothering are traditionally feminine spaces that rely on prescribed gender performances. Anti-fatness impacts "standards dictating how, and in what kind of body, femaleness (and motherhood) can be performed" (Davidson and Lewin 2018: 34). There are consequences if one does not perform gender 'correctly', and this extends harsher punishments to those who have bodies out of bounds (Butler 1988; Versluis, Agostino, and Cassidy 2020). In order to perform femininity, fat women must work harder (wearing makeup, skirts or dresses, and jewelry) to appear as feminine as thin women who do not wear makeup, skirts or dresses, and jewelry (Ospina 2017). This performance impacts how a fat woman is assessed by others and often themselves–thus, contributing to their maternal identities (Versluis et al. 2020).

Gender significantly impacts a person's experience of weight stigma (Farrell 2011; Drury and Louis 2002; Brown 2015), as fatness, understood as excess, cannot truly fit in the box of conventional femininity (Versluis et al. 2020). Indeed, gender is deeply tied to identity in the United States (Rice 2014), where women are taught to continuously regulate and discipline their bodies to perform normative femininity, especially as it relates to weight (Fahs 2017). This often manifests as a constant attempt to take up as little space as possible, both physically and metaphorically (Rice 2014). Saguy (2013) explains that women are more likely to pursue weight

loss by dieting and prescription drug use, and to undergo weight loss surgery than men. Weight loss surgery (WLS) is often recommended as a catchall solution to any number of medical conditions with 'fairy-tale'-like promised outcomes–perhaps this is how women will lure their princes (Groven et al. 2018). WLS is also disproportionately gendered, with more than 80% of surgeries from 1998 to 2010 having been performed on women (Fuchs et al. 2014). Many studies have shown that in the first year after surgery, patients often see both weight loss and improvement of other conditions like blood pressure and sleep apnea, as well as a higher reported quality of life (Janik et al. 2016). However, after the one year mark, people who have undergone WLS often begin to regain weight and show decreased quality of life and psychological well being (Galli et al. 2018). After ten years, WLS patients report a significant overall drop in quality of life (Galli et al. 2018)[6]. Richardson (2004) points out that those who undergo WLS require subsequent surgeries to fix problems associated with the original surgery, facing further risk. Moreover, doctors often stop counting deaths related to surgery after 30 days though the risk of related death remains high–indicating that the death rates associated with WLS are likely underestimated (Richardson 2004).

To illustrate how women internalize notions of femininity, Fahs (2017) conducted a qualitative study in which women were asked about the most dreadful body they could imagine inhabiting. These women most often feared being "'too much'… too fat, too old, too sick, too disabled, too queer, or too Black" (Fahs 2017: 190). The participants feared their gender would be interpreted as less feminine (or not feminine at all) with the intersection of any of these qualities. This study also underlines what traits are desired and required for femininity: thinness,

[6] A major issue with most studies measuring post-surgery success is the sole focus on whether or not weight loss has been maintained. Despite the number of known negative side effects from the surgery itself and the negative long-term psychological impact of this surgery, we are still laser focused on the number on the scale.

whiteness, heterosexuality, cisgender bodied, and able bodiedness (Fahs 2017). Lind (2020) argues that fatness both queers gender and disrupts white hegemony.

This is not to say that men do not experience weight stigma, as this is documented as well (Bell and McNaughton 2007). However, especially as gender and weight interact with parenting, fat women face much harsher social expectations as mothers than do fat fathers. One example of this is the mostly positive label 'dad bod,' or, a dad who is slightly chubby and considered sexually desirable (Elan 2021). There is no positive equivalent for mothers, who are labeled as having undesirable 'frumpy' "mom bods" that are a result of having children and 'letting themselves go' (Dickson 2018). For dads, softness in their bodies is inviting and sexy, but for mothers it is unfeminine and reflects upon her inability to care for herself and others. Fat is the opposite of what a good mother is (Davidson and Lewin 2018).

Racial origins of anti-fatness

Anti-Blackness and anti-fatness are intrinsically linked, as "obesity" rhetoric is embedded in racist structures and body work. If you have ever heard the phrase "they/she/he really let themselves go", you are hearing about a body out of bounds. As Farrell (2011) writes, "the *body in excess* is key to these representations of racial inferiority–the fat mammy, the jezebel figure with protruding buttocks, or, in contemporary American life, the image of the fat (and over-sexed and over-fertile) Black 'welfare queen'" (75, emphasis original). Fatness has repeatedly been tied to "notions of the primitive" (Farrell 2011) and the uncivil (Lind 2020). More subtly, fatness (read as a lack of motivation and willpower) became branded as un-American in the pre-World War II era by medical professionals (Schwartz 1986; Vester 2010). This message was first

distributed via medical journals but quickly bled over into popular media of the time (Vester 2010).

Further, anti-fat rhetoric was included in eugenics narratives in an effort to eradicate fat or potentially fat people. In the late 19th century in the United States, there was a rise of media, in the form of cartoons and postcards, disseminating the ideology that "fat, immigrant, ethnic bod[ies]" were dirty and untrustworthy (Farrell 2011: 77). By 1915, American doctors were writing about Jewish people and their "racial factor" predisposing them to obesity (Farrell 2011: 78). For physicians of the time, it was "inferior bodies" leading to fatness in Jewish people, but for psychologists it was "inferior culture" (Farrell 2011: 80). In the 1930s, Jewish immigrant mothers were stigmatized as bad mothers for their tendency to "smother" their children in their position as uncivilized, non-white[7] people (Strings 2019). Rhetoric of the first half of the twentieth century in the United States frequently relied on fatness to degrade and mock working class, Jewish immigrant women- particularly in their mothering (Schwartz 1986). Fatness was deeply stigmatized as uncivilized and "disgusting", passed down generationally (Farrell 2011: 80). This understanding of fatness was also prevalent in medical models of fatness and 'obesity' research, where doctors attempted to connect racialized bodies and fatness (Schwartz 1986). This led to a slew of eugenicist research in the *Journal of the American Medical Association* stating pregnant white women must undergo strict dieting and weight management in order to help the "virility of the [white] race" (Strings 2019: 194). Fitness enthusiasts of the time echoed this sentiment, urging white women to become stronger and thinner in order to make more white babies (Waxman 2022). Thinness was, and still is, whiteness.

[7] Jewish people have been aligned with and separated from whiteness throughout history. While Judaism is an ethno-religion, and has been racialized in the United States, it is not a race (Strings 2019).

Most prominently, however, normative discourse consistently associates higher weights with Blackness (Saukko 1999). Strings (2019) writes that as racial theories were being formed, the key theorists involved spent a significant amount of time trying to physically differentiate white people from non-white people, with a focus on women. Traits used included "skin color, hair texture, facial features, sexual traits, and body size" (Farrell 2011: 83). These differences were specifically meant to show white superiority and used Black bodies especially to highlight any physical 'flaws' they could. One of those 'flaws' most frequently attributed to Black women was fatness.

These racial theorists tied this to the (made up) notion that Black people could not control their eating habits (Strings 2019). This was at a time when monitoring food intake (the beginnings of intentional dieting) was on the rise and considered extremely important morally, as well as being tied to health and class (Webb 2009). These racist ideals have extended to pregnancy, and it is important to note that both thin and fat people of color face higher levels of reproductive discipline and maternal mortality rates than do fat white pregnant people (Parker and Pausé 2018; Hoyert 2022).

Weight Stigma

Weight stigma is the embodied discrimination against a person based on their physical weight, most severely impacting the fattest people (Chrisler and Barney 2017). Weight stigma is the result of anti-fatness, or the fear and disgust of fat (Robinson et al. 1993). Anti-fat ideology is embraced and perpetuated by both thin and fat people alike (Your Fat Friend 2020; Parker and Pause 2007). Weight stigma is the resulting culmination of anti-fat stereotypes and prejudices that frame fatness and fat people as lazy, disgusting, out of control, and a burden on their

communities (Pause 2017). This dissertation is concerned, in part, with the social and cultural work that weight stigma discourse does alongside the work that fat mothers do in and around it. I ground this work in fat studies. More specifically, I use 'fat' to describe embodied realities, rejecting the medicalized 'obesity' except in discussions of medical pathologization. Further, fat studies scholars expand Kafer's (2013) and other disability scholars' usage of 'harsh' language as a political statement. For example, some fat people use 'death fat' as a way to reclaim the medicalized term 'morbid obesity'. Medicalized body weight categorizations "lead to discrimination and loss of power" in many aspects of our social world (Jaffe 2008: 15). While the medicalized categories of 'overweight' and 'obese' appear to be specific and scientific, they are, like all medicalized categories, open to interpretation and changes. In 1998, the World Health Organization (WHO) and the National Institutes of Health (NIH) lowered the cut off ranges for 'overweight' and 'obese', making 29 million Americans 'obese' overnight ("Who's fat? New definition adopted" 1998). When asked why the new numbers and categories were chosen, the International Obesity Taskforce, the WHO, and the NIH all said the numbers were simply easier to remember (Saguy 2013). Further, these numbers are rarely specified in news reporting of obesity and overweight (Lawrence 2004). A parallel to this would be 'old' and 'young' as age descriptors: who is old or young changes based on varying circumstances. As age and weight are socially constructed categories, ageism and sizeism work in very similar ways and are both, as is motherhood, acquired identities. As such, it is important to outline discourse about fatness and its impacts on the lived fat experience.

One such experience is that of mothering. For instance, how does navigating "a topography of fatphobia throughout the maternity care experience" impact the identity of mothers? (Parker and Pause 2018: 28). This topography "constitutes a terrain of interpersonal

and physical, overt and subtle, encounters leading to the systemic oppression of fatness" (28). As Fahs (2019) points out, while the more "mild" instances of general anti-fatness are often discussed, the hatred and disgust of fatness and fat people is overlooked (246). This hatred and disgust manifests in a particularly violent way in matters of fat reproductive justice.

One such insidious channel is through constant microaggressions, microinsults, microinvalidations and microassaults intended to discipline fat (and potentially fat) people (Munro 2017). The term 'microaggression' was first coined in 1970 by Chester Pierce to name the constant, commonplace racist interactions and confrontations faced by Black people. It has since been expanded to understand queerphobia (Balsam et al. 2011), sexism (Judson 2014), and ableism (Trybus 2019), among other inequalities. More recently, fat studies scholars have argued for using a microaggression framework to understand the multitude of anti-fat messages directed at both fat and potentially fat people (Hunt and Rhodes 2018).

Most fat people experience a constant barrage of verbal, spatial, and visual messages that add up to very damaging outcomes. Weight specific microaggressions can happen spatially in the form of too-small medical gowns at doctors' offices or ever-decreasing public transportation seat sizes. 'Concern trolling' is a frequently deployed verbal weight-based microinvalidation that often comes from friends, family, and doctors who may believe they are truly helping fat people. 'Kinder' (if you can call it that) messages range from "you could be so much happier if you just lost weight" to what amounts to violent fantasies of death, "I'm worried that if you don't change you'll die". Both are examples of anticipation of the future impacting the present. Concern trolling can also create a sense of anticipatory anxiety or pressure for fat people who may feel like they need to constantly monitor and regulate their weight and health-related behaviors in order to avoid negative social judgments or criticisms (Puhl and Heuer 2009; Holi 2019). This

surveillance can create a constant state of vigilance and stress, negatively affecting mental and physical health over time (Puhl and Heuer 2009; Holi 2019). It is also significantly worse for anyone whose fatness intersects with other marginalized categories, i.e., Black, disabled, queer.

More often, though, fat people are subject to concern trolling in the form of microassaults that include derogatory name calling, threats of impending death, and shame (Munro 2017). Reiheld (2020) describes weight-based microaggressions targeted at people not currently fat as "cautionary compliments" (217). Growing up in the Deep South, I've heard "a moment on the lips, forever on the hips" more times than I can count. These cautionary messages remind thin and fat people alike that their behaviors have fat consequences and that our bodies are constantly surveilled. Using euphemisms like "fluffy" to avoid the word "fat" is one example of an anti-fat microinsult. These euphemisms suggest that being fat is something to be ashamed of and not directly acknowledged. Microaggressions, microinsults, microinvalidations and microassaults work to discipline bodies deemed both currently and potentially out of bounds through anticipatory regimes.

Further, a fat person who is marginalized in other aspects of their identity may receive compounding microaggressions specifically targeting their intersecting identities. Reiheld (2020) provides the example of a fat, disabled person needing, but being unable to find, a wheelchair suited for high weights that is wide enough to comfortably fit their fat body. Microaggressions directed at fat pregnant people specifically have been documented in reproductive health literature (Fahs 2019). Fat pregnant people are given shaming morality lectures about what they eat and their bodies (Parker 2017). In a qualitative study of fat women's experiences with their doctor's pregnancy weight management techniques, Parker (2017) found fat women experience high levels of weight-based shame that resulted in "excessive or sub-optimal eating and exercise

behaviors, social isolation, and anxiety and depression, all of which comprise a healthy pregnancy" (30).

Medicalization

Medicalization is the process through which life experiences become pathologized though they were not considered medical problems before (Maturo 2012). The process of medicalization was categorized by Conrad (2007) into three levels: conceptual, institutional, and interactional. Conceptual medicalization of fatness, for example, can be seen in categorizing varying body sizes as "underweight," "overweight," "obese," and "morbidly obese." Where bodies have naturally varied in size for as long as people have existed, these medicalized categories move body size into a pathologized space. Further, they have a serious impact on how bodies move through the social world and medical systems.

For instance, one effect of medicalization is the perception that fat people are always at risk to themselves and society (LaMarre et al. 2020: 339). This 'risk' is both in the present, but also projected into the future as the 'obesity' "time-bomb" (Evans 2020). This idea of a future threat is an important theme that weaves through much anti-fat rhetoric. As an example of institutional medicalization, medical communities assert that fat people are unable to have safe pregnancies and low intervention births (Parker and Pause 2018: 24). In a parallel and sometimes intersectional fashion, low income women's bodies are considered unruly and to blame for any negative birth outcomes (Bridges 2011). The use of state aid to access prenatal care can force low-income women to become entangled in an extensive regulatory system that goes beyond the scope of the pregnancy care they initially sought (Bridges 2011). Low-income women's fertility is often perceived as a drain on the nation's resources, leading to a eugenicist focus on population

control measures that can perpetuate social inequality and exacerbate health disparities. Like fat women, poor women are often medicalized as problematic entities resulting in their bodies being subject to intense scrutiny and regulation (Bridges 2011). In situating fatness as a risk factor for future or potential illness, fat people are subjected to increased medical surveillance (Canipe 2012: 7). However, the impact of surveillance is even more pronounced for Black women, who are subjected to hyper surveillance during pregnancy (Bridges 2011; Waggoner 2017). The intersection of fatness and Blackness compounds the effect of this surveillance, leading to even greater inequality and potential harm for fat Black women. Contemporary understandings of risk in pregnancy and pre-pregnancy often omit that the foundations of these ideals are rooted in historical eugenics movements (Waggoner 2017).

Interactional medicalization also functions as a disciplinary measure wherein fat people are assessed by medical staff who then anticipate futures and suggest behaviors that are allegedly risk-reducing. As a result of anticipatory regimes, even if a fat person never encounters any negative health outcomes, the anticipation of disaster has already impacted their life (Adams et al. 2009). Medicalization, then, conveys specific "*truths"* about what it means to be fat, further marginalizing fat bodies while simultaneously encouraging access to read the fat body as understandable from the outside (Afful and Ricciardelli 2015). The implication, then, is that to look at a fat person is to make a host of assumptions about their story and health status.

Many people struggling to conceive turn to medical care providers for help. One such route is in vitro fertilization, or IVF. Unfortunately, fat people seeking this treatment are often turned away based on weight (or more often, BMI) alone (Davidson and Lewin 2018). Some argue that having a weight cutoff (which is arbitrary and not standardized) requirement at all is due to higher risks associated with pregnancy and IVF in fat people (Turner-McGrievy and Grant

2015) but others view weight-based policies as discrimination (Kaye et al. 2016). Fertility specialists don't agree on what cut offs are best or if they are needed at all (Kaye et al. 2016). Kaye et al. (2016) found that over 60% of IVF facilities surveyed had a written policy on offering IVF to "obese" patients and all large centers (which they quantify as those who manage more than 1,000 cycles annually) had a written policy. Further, 84% of all clinics surveyed had a maximum BMI for IVF procedures: "21.4% set a limit between 35 and <40, 28.6% restrict at a BMI of 40, 14.3% set a limit between 40 and <45, and 9.5% set a limit at 45" (Kaye et al 2016: 705). Only one clinic allowed patients with a BMI over 50 to access fertility procedures (Kaye et al. 2016).

Turning to an earlier study, Turner-McGrievy and Grant (2015) found that of 347 fertility clinics in the United States providing IVF, 120 used either a body weight or BMI cut off for people seeking fertility treatment. These numbers only reflect explicit weight cut offs and likely do not account for standard practices at each clinic. As Zolotor and Carlough (2014) note, many prenatal care standards come from "tradition and a lack of firm evidence base" (199) and Kelley et al. (2019) found that whether or not clinics institute a weight cut off is "arbitrary, rather than evidence-based" (1118). Importantly, most fertility specialists surveyed believed fat patients seeking fertility treatment should first consult with a bariatric surgeon (Kelley et al. 2019)--a finding that was corroborated by another study (Kaye et al. 2016). In fact, the survey showed that many clinics immediately refer "obese" patients to weight loss surgery clinics as a first step in fertility treatment. Again, this invasive, dangerous, expensive surgery is seen as the first step in family planning for fat people rather than any kind of professional consensus on exactly *why* IVF treatment is not suitable for fat people. From an inequality perspective, this approach reinforces the stereotype that fatness is a personal failing that needs to be "fixed" before fat individuals can

pursue family planning. The failure to provide fertility treatment to fat patients until they have lost weight may permanently delay fertility treatment as long-term weight loss is a myth (Crowe 2014). This arbitrary rule dictates who does, and who does not, receive medical intervention and care and who does, or does not, end up with children making it eugenicist in spirit and outcome.

Motherhood as an institution has also become increasingly medicalized over the last 100 years. Campbell (2017) outlines the movement from mothering as an 'instinct' into a discourse of 'risk' with a strong emphasis on holding a mother's body responsible for "a broad range of social problems [that] are reduced to defective mothering" (122). One of the biggest contributors to this was the shift from home births to hospital births, a prime example of interactional medicalization (Apple 2014). A mother's every move now takes place under the microscope analyzing everything from what she eats to how she feels in an attempt to promote fetal health even before they become pregnant (Waggoner 2017).

Mothers who refuse to comply, or are unable to comply, with the hyper-surveillance of medicalized mothering are framed as 'bad mothers' (Ioannoni 2017; Bridges 2011). Feminist scholars have argued that through medicalization, power is taken from pregnant mothers and transferred to medical professionals (Neiterman 2013). Two large campaigns around the danger of exposure to alcohol and/or cocaine while in utero created massive moral panic in the United States in the 1980s and 1990s as part of the racist and classist 'war on drugs.' Moral panic (Cohen 1972) is a widespread fear, often unfounded, that a particular individual or entity endangers the principles, concerns, or welfare of a community or society. This concept is frequently used to describe the effect of framing fatness as an 'obesity epidemic', which results in hostility to fat people (LeBesco 2010). Fatness is framed as harmful and an immediate, serious threat to societal values (Quirke 2016; Saguy and Riley, 2005). Any mother who engaged in

alcohol and/or drug use in *any* capacity was framed as a '*Bad Mother.'* These campaigns disproportionately targeted Black mothers and poor mothers. However, longitudinal studies found that poverty- not cocaine exposure- played a large role in impacting development and overall cognition in children (Anderson 2014). It is possible that economic policies in the United States pose a greater risk to the development of fetuses than a parent's weight. The hyper-surveillance and moral panic that followed these medicalized campaigns is not dissimilar to that of weight in pregnancy. The medicalization of pregnancy has wide reaching consequences that disproportionately affect marginalized mothers. For example, for fat queer mothers, navigating messages about the dangers of high weight pregnancies while also navigating every day queerphobia can be paralyzing (Davidson and Lewin 2018).

Medicalization and hyperfocus on women's bodies during pregnancy and in mothering expanded to weight in the 1990s. This has been quickly increasing since, and some argue that the medicalization of fat is used as a tool to sustain class differences (Dickman 2015). Health, and thinness, are constructed as middle-class values (Dickman 2015) and, as aforementioned, whiteness. Faced with constant scientific and cultural "obesity epidemic" rhetoric, fat mothers are burdened with managing their "risky" bodies. Parker and Pause (2018) also argue that this has a negative impact on mother's identity as they (and their fat bodies) are framed in opposition to their child's body. Their fat bodies have become a threat to their children now and in the future.

Sociology of Mothering

As previously stated, this study operationalizes "mother" as someone who identifies as such. Family roles are "performed, interactional, and [act as a] source of identity" (Biblarz and Savci 2010: 481). Normative/nuclear, heteropatriarchal, and white supremacist definitions of

motherhood usually operate within monomaternalism, or the idea that a child only has one “real” mother (Park 2013). This understanding of motherhood excludes not only lesbian, trans, and genderqueer social parents from being regarded as ‘real’ mothers, but also individuals and communities worldwide who do not conform to the nuclear family model, including various forms of extended family structures that coexist alongside nuclear families (Biblarz and Savci 2010). Patton-Imani (2020) describes the structural inequality perpetuated by delegitimizing queer and social mothers, writing “the stakes in these family policy debates speaks to…how inequality is reproduced in stealthy ways that deny structural power and blame individual actions for social problems” (8). Monomaternalism also creates stressors and unequal social status for social lesbian comothers, which jeopardizes their relationships both with each other and their children (Biblarz and Savci 2010). There are various mothering practices that queer and subvert the traditional notions of motherhood, whether through intentional or unintentional means, and resist the perpetuation of heteronormative ideals (Park 2013). Mothering queerly extends beyond queer mothers to include “(heterosexual) divorce-extended, adoptive, and polygamous families", rejecting monomaternalism (Park 2013: 256).

The following section explores the ways in which motherhood is governed by social control in the United States by drawing on the work of Murray (2013), Hays (1996), Edin and Kefalas (2005), Lareau (2003), and Stone and Lovejoy (2020). I draw parallels between poor and fat mothers and unpack what makes ‘good’ mothers to show how the concept of "good mothering" is a way of enforcing surveillance over women and of maintaining social inequality. Colen (1986) describes this phenomenon as stratified reproduction- wherein certain women's reproductive practices are valued and supported while others are actively denigrated and dismantled.

The family as an institution has long been under social control (Foucault 1990). Murray (2013) quotes Bentham's conception of a Panopticon, which "allowed prison officials to observe all of the prisoners without the prisoners being able to tell whether they were being watched" (165). Mothering in the U.S. operates under a panopticon, as mothers vie for "good mother" titles through intensive mothering (Hays 1996) and concerted cultivation (Lareau 2003)--parenting practices that centralize children and subordinate mothers. Indeed, Stone and Lovejoy (2020) argue that high-achieving mothers—mothers who attended the most selective schools, which led to highly coveted positions in the workforce—have left the workforce and experience a "paradox of privilege" (20). As a result of obstinate, androcentric workplaces and assortative partnering (the social pattern of partnering with similarly educated individuals), mothers "opt out" of their careers. In doing so, husbands' careers are prioritized and women subordinate themselves to their children—both of which exacerbate gender inequality.

Prioritizing their husbands' careers amplifies gender inequality, while ensuring the intergenerational transmission of status for their children intensifies wealth inequality. Why do mothers do this? As wealth inequality continues to widen, mothers feel increased pressure to ensure their children can compete—which increases the need for intensive mothering. Intensive mothering consumes mothers' lives, creating a "panoptic force" that "creat[es] a culture of motherhood in which mothers are rigorously scrutinized and, in turn, rigorously scrutinize themselves and others" (Murray 2013: 168). Murray refers to mothers as "panopti-moms"--a clever way to discuss the intense monitoring of mothering. Importantly, children's success is not simply about advancing the next generation, it is a testament to maternal sacrifice and "good" mothering (Byers and Wiliams 2021). May the best mother win.

Indeed, Murray (2013) argues that mothers are charged with caring for and ensuring the health and safety of their children. Mothers are expected to meet every need their child has (O'Reilly 2004). In their groundbreaking research, Edin and Kefalas (2005) note that poor mothers have children as a way to create meaning in their lives. To the mothers they spoke with, the key to being a good mother was "being there" (Edin and Kefalas 2005: 10). While these mothers do not have the means to adhere to concerted cultivation, they are no less committed mothers. They develop strategies to earn their "good" mother titles–which means they are also enacting the "panopti-mom" paradigm. As an example, most mothers changed their behavior "overnight" when they learned they were having a baby (Edin and Kefalas 2005: 53). Their goal was to provide the best future they could for their children–an adaptation they expected of all mothers. The mothers engage in early motherhood because their children are their legacies; thus, anticipation of meeting their children's needs in the future may have shaped their pregnancies and certainly influenced their mothering (Waggoner 2017). Motherhood was "the point at which they [could] really start living" because children were their "chief source of identity and meaning" (Edin and Kefalas 2005: 6). McMahon's (1995) analysis of low income mothers had similar findings: motherhood became an identity that established them as adults.

As a society, however, the U.S. castigates poor mothers for having children they cannot afford. An emphasis on making sure their babies are clean and dressed nicely in public is of the utmost importance even when money is extremely tight (Edin and Kefalas 2005). To do otherwise reflected negatively on them and their image as a good mother. Importantly, mothers developed a type of metric for gauging good mothering–if other mothers themselves wore nice clothes or had their nails done, but their children were not taken care of, they were deemed "bad"

mothers. In fact, the worse a mother looked in juxtaposition to her children, the more respect she earned.

Research shows that low income families spend proportionally more money on their children than do higher income families (Pugh 2009). Spending money, as long as it is for their children, becomes care work (Pugh 2009) and, again, may earn the mothers public praise. The stakes are high: mothers and their children are at risk of social discipline should they not fit in (Pugh 2009). This dissertation seeks to understand whether fat mothers, like poor mothers, are castigated for having children when they are fat. Should fat mothers forgo parenthood?

Mothers who cannot "be there" (Edin and Kefalas 2011) for their children at all times may hire other women (often mothers themselves) who they can regulate (Macdonald 2010). In fact, MacDonald (2010) shows that high income/professional mothers both delegate mothering to and script their "shadow mothers" to ensure that their children are being exposed to enriching activities and an expansive vocabulary—again, with the goal of cultivating a competitive child (Lareau 2003) through "good" or intensive mothering practices (Hays 1996). Controlling "shadow mothers" ensures the transmission of status to children, but also mitigates the risk of women being accused of "abdicat[ing] her maternal role" (Murray 2013: 170). In this way, mothers who hire caregivers become the mechanism that enforces surveillance over those who mother their children—which, arguably, is to earn them the "good" mother title. Mothers, then, spend significant resources on the development of their children to increase the odds that they will achieve future success. In doing so, mothers reinforce their good mother identities–they and others view them as successful mothers. For fat mothers, an anticipatory regime further disciplines fat mothers through the association of fatness with early, untimely death (Adams et al. 2009). If mothers are fat, the logic flows, they will not be able to "be there" for their children for

long. And, to their detriment, they cannot simply hire others to do their "good" mothering in their absence, because their children will still be exposed to them when they are present.

Indeed, mothers are framed as responsible for both their children's and their own weight, and if their child is fat, mothers are blamed (Ioannoni 2017). Mothers are shamed and fat children are "humiliated" in public discourse that attempts to frame fat children as "reflective of bad parenting" (Ioannoni 2017:166; Davidson and Lewin 2018). The mother blame acts to discipline mothers in their role as nurturers responsible for feeding their children, where their (fat) children are a visible marker of failed motherhood. Even though part of "being there" for children is through feeding the family (DeVault 1991), fat mothers' feeding is fraught with current and potential danger. Women have historically been expected to feed and nurture those around them, but fat women are read as unable to appropriately feed themselves or anyone around them (Versluis, Agostino, and Cassidy 2020). This intersects with the controlling image of the Black mammy, who takes care of and feeds white children soul food (Morris 2019). Soul food is stigmatized as unhealthy and the mammy is seen as out of control and larger than life (Hill Collins 2000; Morris 2019). This is another example of how gender, fatness, and race interact with each other. Feeding the family is just one aspect of body maintenance, but is deeply embedded in how we understand the raced, classed, and gendered mother (Davidson and Lewin 2018)

To demonstrate the ways in which fat mothers' feeding practices are considered dangerous, an examination of legal cases is necessary. One way fat mothers are disciplined is through the state, with children's weight being more and more frequently positioned as a site of abuse and neglect (Quirke 2016; Bell et. al. 2009; Solovay 2000). The weight of a child or their parent has been used in custody battles, often as an indicator of who is and is not fit to parent. A

Missouri custody battle was decided in favor of a father who argued his ex-wife's weight was a potential danger to their child ("Child Custody a "Weighted" Issue?" 2020). The 'expert' advice in the case was provided by doctors who argued for the potential of serious health concerns for the child later in life should the child remain with their fat mother. This argument assumes that fat parents always have (or raise) fat children, and that this is an inherently dangerous future. How can a fat mother be a good mother when the anticipated intergenerational transmission of fatness legally stopped her from "being there"?

Sadly, the case did not simply impact one family. Rather, the Stange Law Firm in Missouri wrote a blog post ("Child Custody a "Weighted" Issue?" 2020) about the incident, providing tips for how their clients can use the weight of their partner to leverage custody decisions. They are not alone in advertising how to address weight in custody battles, leveraging children's body size as a weapon. In 2013, The Gielow, Groom, Terpstra, and McEvoy law firm posted a similar article about the rise in children's weight playing a central role in custody battles. In this case, too, the potential, future 'consequences' of weight were used to decide custody (A 'weighty' issue: When a child's weight becomes a factor in custody, 2013). This is a denial of parenthood based on what Goffman (1963) describes as a discrediting attribute. According to Goffman (1963) discrediting attributes can be visible, like race or body size, and invisible, like mental illness or criminal record. Regardless, this demonstrates that access to parenting can be decided based on weight and demonstrates that weight may be commodified to generate business for institutions that perpetuate fat inequality.

These custody decisions are not always a result of divorce. Government agencies have removed children from their families based on weight. Badshah (2021) noted a 2014 report that found 74 fat children removed from their homes in a 5-year period in the UK, *only* on the basis

of the children's fatness. In 2011, an 8 year old boy was placed into foster care in Ohio when social workers decided his mother was unable to control his weight (Dissell 2011 and D'Arcy 2011). The Cuyahoga County Department of Children and Family Services accused the mother of medical neglect and creating an unfit environment based on his size alone (Dissell 2011). The child's mother was blamed for failing to sufficiently control her child's body, and the state argued that the child was left at significant risk of future disease and ill health. While the child had no health problems when he was removed from his family, the state concluded that the anticipation of disease was important enough for removal. In this case, like many others, the state defined what it deems a viable future; one free from fatness and/or disability. The anticipation of future illness based on fatphobic ideas about weight led to the removal of this child from his family.

Turning to another case from 2009, a 14 year old boy was placed in foster care and his mother was charged with criminal neglect when the South Carolina Department of Social Services said she was putting her son at serious risk of medical complications based on his weight alone (Barnett 2009). In both of these cases the mothers were poor, highlighting the intersecting surveillance faced by poor, fat families (Dissell 2011 and Barnett 2009).

More recently in the United Kingdom, two teenagers were placed in foster care after they failed to lose enough weight to please the judge assigned to their case (Badshah 2021). The judge went on record to note how the parents were loving and that "the children had clearly had some very good parenting, as they were polite, bright, and engaging", but simultaneously scolded the parents for not understanding the "seriousness" of obesity (Badshah 2021). This situation occurred during the COVID-19 pandemic lockdown, where the family was unable to leave the house. The courts used an 'inconsistent' attendance at Weight Watchers meetings and a lack of gym attendance as two of the reasons the parents were unfit to take care of these children-

despite country-wide social distancing and isolation orders. There was no mention of any disease or ill health in these teenagers outside of their 'obesity' diagnosis. Children in loving, happy families may be removed and placed into state foster care systems, then, based on anticipation of future illness and interlocking systems of inequality.

Pre-Pregnancy

Important to note, the impacts of medical weight stigma and anticipatory regimes can be felt long before one becomes pregnant (Waggoner 2017). Barriers to family planning in the form of conception aids and contraception are abundant. In some cases, like with birth control pills, this is because fat people are left out of research trials entirely (Mody and Han 2014). In other cases, the exclusion comes from doctors and clinics refusing to take on "obese" patients (Eyal 2013). Social and institutional barriers to reproductive care are created through policies and debates about fat parents' fitness to mothering (LaMarre et al. 2020).

There are many different options for birth control currently available in the United States. While there are non-hormonal options like condoms, non-hormonal intrauterine devices (IUDs) and spermicides, I specifically discuss hormonal options as they often are impacted by weight[8]. Hormonal birth control is almost always administered to people assigned female at birth and impacts how the body functions, compared to a discardable, one-time use condom that does not affect bodily functions outside of its momentary use. Hormonal birth control methods include pills, hormonal IUDs, patches, and implants in the arm. While the specifics of each option is outside the scope of this dissertation, it is important to note that most are not as effective for fat people (Stacy 2020). This fact lives at a strange crossroads of not being a secret but simultaneously not being discussed or widely acknowledged. Since at least 1980, clinicians have

[8] However, it is important to note that weight stigma can still be present and impact individuals' decisions to use non-hormonal methods.

known that fatness increases the risk of contraceptive failure (Edelman et al. 2017). Studies on birth control effectiveness did not begin including fat people into their trials until the 2010s (Edelman et al. 2017). Even still, these trials have not included higher and highest weight individuals (Edelman et al. 2017). Fat people have been left with limited options for effective contraceptives and, therefore, are at higher risk of unintended pregnancies (Edelman et al. 2017).

The standard, over the counter emergency contraceptive, levonorgestrel, has a weight limit of 155 lbs (Bruess 2021). It is now recommended that fat people (or, anyone over 155 pounds) take a double dosage of Plan B. This is an increased financial burden that could be avoided if the manufacturers offered different dosage levels for the emergency contraceptive. The alternative most often recommended to larger people seeking emergency contraception is ulipristal acetate, with a weight limit of 195 lbs *and* a lower efficacy rate (60%-85% compared to Plan B's 60%-94%) (Bruess 2021). Furthermore, Ella is less widely accessible and requires a prescription: both increase barriers to reproductive care if someone is unable to get an appointment with their doctor. The weight limit for Ella is only marginally better and still excludes a significant portion of people who may need emergency contraception. The lack of options for fat people seeking emergency contraceptives is reproductively unjust. Fat people are simply not considered in the spaces of postcoital contraception.

Pregnancy

The documented violence experienced by fat pregnant people is important as it shapes the very beginning of parenthood for many fat people. Pregnancy is categorized as a risky process largely controlled by individual behavior in Western medicine (Lauridsen 2020). Fat people who are able to become pregnant are encouraged to get their weight "under control" first (Waggoner

2017: 7). Fat pregnant people have been designated as automatically *high* risk pregnancies (Lauridsen 2020). As Canipe (2012) demonstrates, medical care providers frequently prescribe riskier 'treatments' for fat pregnant people that are "questionable" for thin pregnant patients. For example, fat pregnant people are often told not to gain any weight at all during pregnancy- even though increased weight is said to help both parent and child before, during, and after birth (17). Canipe (2012) points out that the focus on weight gain during pregnancy is a focus not on actual pregnancy risks, but on "controlling the pre-pregnancy and post-partum body" (18). Jette and Rail (2014) point out that fat women are framed as "major contributors to the obesity epidemic" due to their pregnancy weight gain *and* when "failing" to lose any weight gained in pregnancy (203). In focusing only on weight and whether or not a person is in an 'acceptable' body to carry a fetus, the parent's needs and lived experiences are erased, as they are reduced to a walking womb.

A second example comes from the "fat vagina theory", which argues fat vaginas over-complicate birth and quite literally 'trap' infants as they are born (Vireday 2010; Davidson and Lewin 2018). The medical term for this is soft tissue dystocia, though 'fat vagina' is more commonly used in everyday practice by clinicians (Vireday 2010). This belief leads many OBGYNs to recommend or require cesarean sections for fat pregnant people even though there is research proving the "clinical insignificance" of vaginal soft tissue build up for birth (Einion and Rinaldi 2018; Wischnik et al. 1992). This popular myth works as just one more way to pathologize the fat body as wrong and incompatible with healthy reproduction (Einion and Rinaldi 2018).

Further, the push for immediate, post-pregnancy weight loss (popularly framed as '*getting your body back*') is damaging. In 2013, the American College of Obstetrics and

Gynecology produced a lifestyle guideline for thin and fat pregnant women laced with an "alarmist tone"; it was then disseminated by the press (Jette and Rail 2014). These messages warned of the dangers of being fat before, during, and after pregnancy. One example of this comes from *The National Post,* a newspaper, with a warning that 'obesity' is as dangerous as smoking and drinking for fetuses, as "obesity during pregnancy may deprive fetus[es] of crucial oxygen" (Blackwell 2012). This claim came from a single study performed on rats that was not able to draw significant conclusions either way. Another alarmist article from 2015 that was published in the *New York Times* argued "the health of the nation rests upon the shoulders" of obese mothers, saying that fat mothers were a danger to themselves, their children, and presented problems for health care providers (Putnam 2015). This rhetoric of panic, disgust, and danger is frequently used in public health initiatives to induce feelings of fear, shame, and panic over weight and fat reproduction (Lupton 2015).

Rather than a passive byproduct of cultural anti-fatness, Parker and Pause (2019) show fat shaming is actively used and embedded in medical care surrounding pregnancy. Having fat children is framed as medical neglect by parents (Lee 2020: 11). One of Parker and Pause's (2019) crucial findings shows one intended effect of institutional fat shaming is for pregnant people to "*feel* deficient and at risk" (253, emphasis original). For many of the participants, the dangers of fat pregnancy were overly emphasized by providers who also made their negative attitudes about fatness visible via "annoyance, disgust, and concern" (Parker and Pause 2019: 258). This shame followed most participants throughout the duration of their pregnancies, impacting their self-worth and identity as parents. Shame has been shown to impact maternal identity development (Thomson et al. 2014). In a study on women's experiences while infant feeding, Thomson et al. (2014) found that negative judgements from others decreased overall

maternal well-being and confidence. This was true for both mothers who breastfed and those who fed with formula, tying the idea of a 'good mother' to one who feeds their family 'correctly' (Thomson et al. 2014; DeVault 1991). Microaggressions are a well documented disciplinary component of weight stigma (Munro 2017; Reiheld 2020). Through this study, I am interested in exploring the extent to which this occurs, and the degree to which it continues to impact new parents.

Conversely, the anticipatory practice of targeting pregnant people for nutrition intervention is widespread and growing as a means to prevent potential "obesity" and diabetes in unborn fetuses (Valdez 2018). Again we see that anticipation is used to both instill fear and govern the future at all costs (Adams et al. 2009). Fat people who experience nausea and vomiting during pregnancy are advised to see this as a positive weight loss mechanism by care providers (Davidson and Lewin 2018). The idea that a mother's weight is a predictor for future illness extends further. An article in *Pediatric Research* from 2011 calls the fat pregnant womb a "suboptimal environment" that is likely to lead to adult adversity for fetuses (Poston et al. 2011: 175). The rest of the article goes on to talk about how this argument needs more research to understand the long-term implications of maternal weight even though they do not shy away from making such claims. Their only solution to *potential* negative health outcomes for pregnant people and their children was preventing maternal 'obesity' entirely, a sentiment shared with the CDC (Waggoner 2017). This, they argued, should be done through encouraging 'healthy' diets and reminding pregnant (and pre-pregnant women of reproductive age) of the dangers of 'obesity' (Poston et al. 2011). Another such example comes from Krakowiak et al. (2012), who found that 'obese' pregnant mothers *may* have an increased risk of gestational diabetes which *may* lead to increased risk of an autistic child. Popular media was quick to draw on this ableist,

anti-fat story. One news outlet editorialized these findings with a scary and shaming lens, ultimately warning that fat women seeking to become pregnant must lose weight or risk a disabled child (CBS News 2013). The study cited in the news report cautioned against assuming cause and effect from the small sample size but the newspaper writing barely addressed this key fact. The outcome is fear and shame, not health. Anticipation was weaponized and the intersections of ableism and anti-fatness are clear. The beginning of parenthood for many people is biological child birth[9] and fat pregnant people are receiving care that goes against best practices to the detriment of their health because of fatphobic social beliefs (Davidson and Lewin 2018)[10].

Summary

Mothering is a gendered experience (Katz-Wise, Priess, and Hyde 2010) further complicated by the influence of anti-fat attitudes on the social norms that regulate the performace of femininity and motherhood (Davidson and Lewin 2018). Fat people are subjected to increased medical surveillance as fatness has been framed as an automatic risk factor for health (Canipe 2012). Family sociologists point out the various ways in which mothers are disciplined (Murray 2013; Stone and Lovejoy 2020) into normative, heteropatriarchal (Park 2013) models of motherhood–even as they navigate parenthood as best they can (Edin and Kefalas 2005). My research aims to address gaps in the literature by investigating how weight stigma impacts fat mothers and how this perception affects their ability to provide safe and healthy environments

[9] See Kelley et al. (2019), Neiterman (2013), Waggoner (2017), and Parker and Pausé (2018) for important discussions of pre-pregnancy surveillance, and the relationship between reproductive technology and 'potential' motherhood.

[10] As Davidson and Lewin (2018) found, fat pregnant people were told to either lose weight or maintain their pre-pregnant weight over the duration of their pregnancy. Thin pregnant people are encouraged to gain weight to support a healthy pregnancy.

for their children. To accomplish this, my research questions focus on exploring how fat women navigate anti-fat environments, the impact of the anticipation of the future on fat mothers, and how discussing anti-fatness might result in fat mothers re-evaluating their experiences in a new light. At every turn, anticipation of a negative, or even disastrous, future is impacting fat mothers ability to "be there". In order to understand the long-term impacts of anti-fat bias on mothers,we must first look at motherhood as a throughline of connected events. As is true with many aspects of our lives, looking towards the future impacts how we move through the present.

CHAPTER 3: METHODOLOGY AND RESEARCH DESIGN

This dissertation focuses on mothering and motherhood as they are impacted by weight stigma. However, following Verseghy and Abel (2018), I do not limit these actions, identities, and the cultural institution to people assigned female at birth who have given birth (11). I situate myself in gray areas to include all people who identify as mothers through birth or adoption, as chosen mothers, as familial mothers, non-conforming mothers and beyond (11). In this project, I do not conflate pregnancy and childbirth with motherhood, but rather as one avenue to motherhood (Sawicki 1999). Pregnant people and people assigned female at birth who parent children may not identify as mothers. Additionally, some gender queer, nonbinary, and/or gender non conforming people who parent children may identify as mothers. For the purposes of this dissertation, participants needed to identify as mothers.

Recruitment included a pre-screening questionnaire in which participants were asked whether or not they identified as mothers prior to the start of the first interview. In total, I interviewed 18 mothers twice, two weeks apart, for a total of 36 interviews via Zoom between January and June of 2022. The first phase of this study was a round of semi-structured interviews lasting approximately one hour. At the conclusion of the first interview, participants were invited to self-select artifacts that represent mothering to them to bring and discuss in a second, hour-long semi-structured interview. These contributions (see The Toy Box section below for more details) were wide-ranging artifacts of importance related to mothering for the participants.

Inviting artifacts: The Toy Box

My Grandmother calls me a magpie. I am a collector of many things to varying extents. I decorate my home with art and flowers and odds and ends. My fridge is decorated with magnets

and my walls are lined with art and photographs and letters I've been sent. These little pieces of my life fill my space with their presence. They tell many stories.

One of my favorite ways to learn about other people is to take a peek around the spaces they spend time in. When you walk into someone's home or office (or see a small corner of their life on Zoom), you see a small piece of them. Even when a room is 'bare' you are learning about the person. Sometimes these meaningful items are tucked away and not so obvious. This may come as an inscription on the first page of a gifted book, or a box of ticket stubs at the top of a bookshelf. Many of us have spent hours pouring over photo albums (physical or digital) when visiting family or old friends. These things, whatever they may be, can prompt stories in a special, emotional way. I wanted to hear these stories.

What counts as knowledge? What is important? What is motherhood? Who decides this? Interviews are incredibly useful and provide rich data. However, some participants eagerly provide in-depth answers, whereas others are less forthcoming. Some may struggle to find the words when asked questions while others are embarrassed or shy. In order to truly understand their experiences and lives, I provided the opportunity for participants to answer my questions by connecting to things in their life that may hold significant meaning. This often made room to revisit the same questions and topics from the first interview in the second.

At the end of the first interview, mothers were given the option to bring an item or items of importance for us to discuss together at the second interview. My script was as follows:

> For the second interview, I invite you to bring an item (or a photograph of the item) from your life that represents your experience of motherhood specifically related to your body and weight. Have you ever gone to a friend or family member's house and looked at what they had displayed on their walls or fridge?

> Or maybe you've sat and looked through photographs or recipes with someone and exchanged stories? Perhaps you have special memories that are attached to an inscription in a book or an item of clothing. What you bring is completely up to you, though I am happy to help you think through this request if you'd like assistance. During our second interview, I would love to hear any stories about the item, why it is important to you, and how the item makes you feel about motherhood and your body.

As someone who doesn't have children or fill a parenting role, any attempt I might have made to determine the best way to collect this information would no doubt have been imposing my ideas of importance on the parents. Instead, I asked that they show me what is important to them as (fat) mothers. Further, I wondered if these items would reflect magnified moments (Hoschchild 1994).

In an analysis of women's advice books, Hoschchild (1994) found important, emotional "magnified moments" throughout that allowed for intimate connection between the author and reader. They were "episodes of heightened importance, either epiphanies, moments of intense glee or unusual insight, or moments in which things go intensely but meaningfully wrong. In either case, the moment stands out; it is metaphorically rich, unusually elaborate and often echoes throughout" (4). While these "magnified moments" were stories, I argue that the items participants may contribute would reflect stories, and allow for the "magnified moment" to be understood in a deeper, illustrative manner.

The items were varied in type and meaning and provided a deeper understanding of the mothers' experiences. This resulted in the Toy Box stories becoming a central part of my analysis. In a similar vein, Jennifer Lee (2020) used a combination of photographs, audio journal

entries, and autoethnography to document her experiences with medical providers as a fat mother. The article is powerful and offers different windows into Lee's life as she navigated fat pregnancy and motherhood. For Lee, using these methodologies was an attempt to "[enhance] the relationship between writer and reader" (2). Importantly, Lee points out that this methodology is "a hopeful act" (2). Through their Toy Box items, participants told stories that were emotional, powerful, and sometimes difficult. In focusing attention on their items, some mothers who were more shy or reserved in our initial interviews seemed to open up with more ease. In this vein, the Toy Box functioned similarly to play therapies (Crenshaw and Stewart 2015) used in behavioral counseling where children use toys and other objects to express emotions. Even for the most verbose participants, the items provided interesting new directions for the second interviews. In an attempt to ensure that the mothers alone interpreted the artifact and its importance to them rather than the research focusing on my interpretation of their items, I do not include any photographs of the artifacts in this dissertation (Rice 2009).

Disrupting Methodologies: Explaining Methodological Choices

Fat people endure constant intrapersonal and institutional objectification and surveillance. Sociological research affirms participants' dignity, humanity, and multiple subjectivities. This exploratory project is geared towards understanding the nuanced experience of fat motherhood. I therefore depart from conventional research (that might be received as being *on* people) and embrace non-traditional, collective methodologies that foreground my aspirations to work *with* people (Pillow 2003). As a fat person myself, I experienced many of the same anti-fat occurrences as the fat mothers I interviewed. However, as I am not a parent in any capacity, there are experiences I do not and cannot know about the intricacies of navigating life as a fat parent.

This methodology was intentionally designed as a space for fat mothers to express the inequality they face as a result of weight stigma.

Making room for "ambiguity" and "disruption" in research leads to deeper intersectional analysis (Rodriguez 2020). An ambiguous design allows for possibilities in comparison to a linear trajectory with an assumed result (Rodriguez 2020: 266). Ambiguity leads to disruptions in research which "enhance our views of who/what gets included/excluded during our fieldwork" (262). Rodriguez (2020) theorizes "disruption" as "a process that involves deconstructionist notions of method(ology), reflexivity, and power relations as researchers engage in analysis and representation of data" (265). The concept of disruption in research builds on Hochschild's (1994) concept of "magnified moments" discussed earlier. Embracing this moves beyond asking for researchers to engage in reflections of their biases and toward learning how to "navigate moments of disruption" (Rodriguez 2020: 263).

Less structure in my interview protocol allowed the mothers to guide the findings in the direction they deemed most important (Harrison 2018: 72). When I initially designed the project, I situated the focus of my questions several years after the participants *became* mothers. As the existing literature on fat motherhood primarily focuses on pregnancy and birth, I aimed to situate this project after years of mothering. However, most of the mothers I spoke with wanted to talk about *becoming* mothers. I found that the moments of becoming were deeply impactful years after parenting. If I had not made room for this in my findings I may not have noticed the important pattern developing. Including the Toy Box in the design of this study allowed for more flexibility and openness in data collection, which meant I received deeper, more meaningful data. Additionally, making room for unexpectedness allowed my participants to shape the experimental Toy Box methodological element, described in detail above.

My study was designed as a set of two interviews with two weeks in between. In general, there exists a high rate of internalized anti-fat stigma held by fat people.[11] Spending more time with each mother allowed me to develop rapport and understanding that led to a more open conversation. Berger (2015) writes that utilizing a sequence of interviews can also help mitigate power imbalances and help maintain researcher reflexivity. As recruitment efforts were online, the initial interview was the first time they saw me via Zoom. Several mothers remarked that they felt relieved they would be talking to a fat person.

At the start of the first interview I asked demographic questions to create context through which to understand their motherhood. Then, I asked questions about their bodies and weight, including their relationships with their bodies. To understand how weight and motherhood interacted I asked questions such as, "Can you describe an experience you've had as a mother that is directly connected to your weight, positive or negative?" We then would discuss what fat motherhood was like for them with questions such as, "How does being fat/plus size impact your mothering day-to-day?" I often followed up with further probing questions to encourage the mothers to elaborate. In priming mothers during the first interview to consider how their bodies played a role in their mothering/parenting experience, I wondered if mothers would come back to the second interview with a different perspective or understanding of the very same (or similar) interview questions. To address this research question, I began the second interview with the

[11] For my master's degree, I interviewed fat women about their experiences with health care providers. Many women recalled fatphobic (and often borderline medical malpractice) experiences before quickly stating that they were responsible for their weight 'problems' and ill health. Many of these women believed it was their fault that they had been ignored or dismissed by their doctors because of their weight. The internalization of these anti-fat messages played a large role in how they navigated medical settings and truly impacted their care as they were unwilling to push back with their dismissive doctors.

questions: “Is there anything you’d like to revisit from our first talk?” and “Do you feel differently today about anything we have previously discussed?” See Appendix A for the full interview guide.

While I set out to have the interviews to occur two weeks apart, a number of obstacles appeared along the way from sick kids to vacations. Scheduling necessarily became more flexible in many cases as I worked to meet the needs of the mothers I spoke with. This sometimes meant early morning or late night interviews and occasionally included cameos from their children. Though I had worried that the Zoom interface would impact our ability to create a rapport, I found the opposite actually happened. Oliffe et al. (2021) wrote that using Zoom, especially within the context of the COVID 19 pandemic, offers an effective platform for qualitative research. This team of researchers found that participants interviewed over Zoom felt at ease discussing their experiences and emotions and did not have trouble navigating the remote setting (Oliffe et al. 2021). This was true for my study, as well.

Especially by the second interview, mothers were talking to me as they fixed meals, folded laundry, breast fed, and otherwise tended to their children. Even when I was thousands of miles away, the conversations flowed like we were sitting on the living room floor together. When our conversations moved into difficult topics and sometimes sad stories, I found myself crying alongside the mothers.

It was clear that these mothers wanted to share their stories for a number of reasons. Nearly all mothers I spoke with explicitly expressed their excitement for the study. For example, at the end of our second interview, Emily, a single mother of one, said “No one is paying attention to the experience of fat motherhood from the lens of people who are actually fat in a

way that reclaims the experiences of actual fat mothers." Other mothers echoed this sentiment that the fat positive standpoint of this research was important to them.

I anticipated that the second round of interviews would provide richer data, including reflections from the participants on their Toy Box contributions and the first interview conversation. In developing this methodology, I wondered if participants would make connections and pull out themes across the interviews and Toy Box artifacts. As Harrison (2018) points out, data collection and data analysis are intertwined. While both the first and second interviews were semi-structured, I leaned more heavily on improvisation (Harrison 2018) in the second interview as what participants wanted or were able to discuss varied greatly based on their artifacts. As an exploratory project, creative methodologies continue to expand these possibilities. Further, and of significant importance, this dissertation is not an attempt to 'give voice' to marginalized people, but rather to listen deeply (Fine 1994)[12].

Participant recruitment

I recruited participants who mother at least one child between the ages of two and ten years old. Having a child (or children) changes anybody, sometimes drastically, no matter what a person's starting weight is. Mothers who are parenting biological children who are at least two

[12] Indigenous scholars note that storytelling and narrative work are extremely important in decolonizing research and knowledge transmission (DeLeon 2010: 398). Decolonizing theory is critical in finding "new way[s] of being and knowing" (Rodriguez 2020: 266). This is especially relevant in my methodological design though I do not claim to do decolonizing research. Storytelling (and personal narrative) has often been used by marginalized communities as a way to respond to othering discourse (Douglas and Poletti: 2016). Storytelling is the art of conveying a narrative or story to an audience using language, imagery, and other sensory details. Storytelling can take many different forms, including spoken word performances, written works, music, and visuals. The power of storytelling lies in its ability to capture the attention of an audience and transport them to another world or perspective. It can inspire, educate, entertain, and challenge our beliefs and understanding of the world around us.

years old are far enough away from childbirth that their weight would not necessarily be considered 'baby weight'. Mothers of all sizes go through bodily changes during pregnancy, some more drastic than others. Socially, we understand 'baby weight' as a temporary fatness that is (for the most part) accepted during and soon after pregnancy but that should also be shed soon after birth (Nash 2012). As the category of fat is not fixed or universal, I do not include specific size descriptions for participants unless they specify them during interviews. I use the terminology participants identify with and use to describe themselves (e.g. fat, plus-sized). Additionally, children between two and ten are still largely dependent upon and connected to their parents.

I recruited participants online by posting a recruitment flier in several parenting-focused Facebook groups. I shared my recruitment flier in seven total groups, some of which were parenting groups specifically for fat/plus size/curvy mothers. The groups ranged in size from several hundred members to nearly one hundred thousand members. A $20 Amazon gift card was advertised on the recruitment flier as compensation for participation. Potential participants were instructed to email me if interested in participating. I anticipated difficulty in recruiting participants as fatness is a stigmatized identity and I was specifically looking to speak with fat people. However, I was excited by the positive responses I received as people self-selected into the study.

Once I received an initial interest email, I responded with an overview of the study timeline and an IRB information sheet. Of the nearly forty people who initially emailed with interest in participating, 18 completed the study. With this limited sample, it is important to reiterate that my findings do not apply to all mothers nor to all phases of motherhood. Participants joined the study via Zoom from all across the continental United States. These Zoom

interviews were recorded with permission from each participant. Throughout the study I took several steps to protect participant confidentiality. Each mother was assigned a participant ID number for handling required university reimbursement documentation for gift cards. This participant ID number was kept separate from personal identifiable information. Additionally, I assigned the mothers with a pseudonym in the final interview transcripts. All study materials were stored on a password protected computer.

Table 1. Characteristics of the Sample.

Pseudonym	**Children**	**Relationship Status**	**Sexuality**	**Age**	**Race/ ethnicity**	**Toy Box Contribution(s)**
Gillian	2, biological	Married	Straight	32	Latina	Long sleeved, full length terry cloth white beach cover up with large pockets and a hood
Maria	2, biological	Married	Straight	33	Latina	A necklace with charms for Saint Gerard, Saint Gianna Beretta Molla, and Saint Catherine of Siena; her breast pump
Susan	2, biological	Married	Straight	43	White	A gown she purchased specifically to wear to the hospital in her size, a unakite necklace
Nena	1, biological	Married	Straight	39	White	A photo of her c-section incision taken by a nurse after surgery at Nena's request
Hayley	1, biological	Married	Straight	35	White	A large sized blood pressure cuff she bought during her pregnancy
Melissa	1, biological	Married	Straight	40	White	The first photo taken of her with her son, where she positioned his head to hide her chin; the hospital gown she purchased and brought to her delivery
Allana	1, biological	Single	Straight	26	Latina	A black pair of jeans she keeps at the back of her closet that are a size too small
Emily	1, biological	Single	Queer	38	White	A photo of herself using a breast pump, a pair of pajama pants she wore frequently during the first year of her

						child's life
Sara	2, biological	Married	Straight	35	Not reported	Her water bottle covered in stickers
Josephine	2, one social, one biological	Single	Not reported	51	White	A staged family photo of herself and her two children; a naked barbie doll
Laura	2, social	Married	Gay	35	Not reported	Hiking boots taken from her mother; a large size baby carrying wrap
Amanda	2, biological	Married	Straight	38	White	Her baby wrap specially designed for plus size bodies
Rebecca	2, biological	Partnered	Straight	40	Not reported	A rocking chair, passed down from three generations in her family
Jessi	2, biological	Married	Straight	24	White	A photo of her baby announcement, the gown she wore at the hospital for delivery gifted by a close family friend
Carla	1, biological	Married	Queer	38	White	A children's book gifted to the family by her mother
Willa	3, biological, 2 living	Married	Straight	43	White	A twin sized breastfeeding pillow
Gemma	3, two biological, one social	Married, partnered*	Gay	40	White	The baby carrier used when their children were toddlers
Brianne	2, biological	Married	Straight	35	Black	Photo of the family minivan

**This participant is married with a partner, the three adults are raising their children together as one family unit.*

Reflexive Statement

As a fat woman and fat studies scholar I have a significant investment in the fat community (whether one identifies as part of it or not) and was open with the people I spoke with about my views on weight. I am also emotionally involved in this work, which situates me in an engaged position. I have no children and have never been pregnant. However, as a fat cis white woman I have had to navigate medical anti-fatness in reproductive spaces for quite some time.

As a feminist researcher, it is important that I highlight the standpoint from which I am doing this work (Ingraham and Borero, 2020). I utilized Fine's (1994) concept of working the hyphens, to locate myself within this project both in relation to and separate from the mothers I spoke with (372). Working the hyphens refers to the idea of navigating the complex and often contradictory intersections of identity, power, and oppression in our society. The space between two or more identities, such as race, class, gender, sexuality, religion, and nationality are ever shifting and changing. These identities are not separate, but rather intersect and influence one another, creating a complex web of experiences and perspectives. Working the hyphens involves acknowledging and embracing these multiple identities, recognizing the ways in which they intersect and interact with each other, and using this understanding to challenge dominant narratives and systems of power and oppression. This concept recognizes that individuals are not defined by one singular identity, but rather exist at the intersection of multiple identities, each with its own unique experiences, challenges, and opportunities.

Rather than simply stating the standpoint from which I come, I attempt to show the ways I, alongside the participants, navigated the study together. At different times, some aspects of my identity were more salient than others, as were the identities of my participants. My positionality and identities may have affected what my participants included or disclosed to me over the course of the project (Cunliffe and Karunanayake, 2013).

The fact that I am not a parent prevents me from understanding nuanced situations I could, or maybe should, be investigating. When asked if I was a mother, I was open with participants that I have never been a mother. This question came up in several interviews but I never felt that I was met with any unease upon my answer. I explained that I was coming to the study as a learner who could benefit from the knowledge of their unique experiences (Berger

2015). I believe this led to deeper, more detailed explanations from participants, because they were educating me on their experiences.

I attempted to reach high levels of engagement with my participants. As Carla Rice (2009) writes, including physical bodies in reflexivity is as important as gender, race, and class positionality (247). My fatness allows me to connect with other fat people in a way not afforded to thin researchers doing this work, but I never went into interviews assuming I would be considered an insider. What I disclosed about myself and my relationship to this work depended on the interview and questions from participants. Several of the participants I spoke with held graduate degrees, and Willa, a married mother of two living children, holds a PhD in sociology. During my interviews with Willa, she had more questions for me than the other mothers and was interested in my research design. In those conversations, I was open with my process and goals. For mothers who did not ask, I did not take up time discussing my own goals and research trajectory.

Analytic Strategy

My overall findings show the various ways fatness impacts the experience of motherhood. Every mother brought a Toy Box item that represented what motherhood means to them to share and talk about. This is one of the primary ways that participants were actively engaged in generating knowledge and creating the data. These items deepened conversations and allowed mothers to narrate their own experiences, which may not have been shared otherwise. In other words, the Toy Box items permitted mothers agency in deciding how to frame their own experiences as mothers. Significantly, in this dissertation I highlight the many instances of joy

and resilience these mothers shared with me, as they are just as important as the instances of trauma and pain.

I used Otter.ai (a transcription software) to build a first pass of the transcripts and then went through each transcript to make edits. To facilitate data management and analysis, I used NVivo software to code the interview data. NVivo is a qualitative data analysis software that allows researchers to organize, categorize, and analyze large sets of qualitative data. To code the data, I started by generating a list of initial codes that emerged from and were informed by my interview notes (taken during and immediately after each interview), research questions, and interview protocol. I went through each interview transcript with my initial codes and subsequent codes were added. After the initial coding I went through each transcript a second time to review previous coding. I then used NVivo to sort and filter the data based on different criteria, such as participant demographics, experiences with health care providers, and Toy Box contributions. This allowed me to identify several patterns and themes.

Throughout this dissertation I do not shy away from including long form quotes from the mothers I spoke with. Rather, I have made a point to present full accounts and stories as they were shared with me. While traditional sociological writing may typically include shorter quotes of 3-4 sentences in writing, part of employing a disruptive methodology in this dissertation included the use of long form quotations in the findings (Viruru and Rios 2021). In doing this, I attempt to show a fuller picture of each mother's experience as presented by the mothers themselves (Viruru and Rios 2021). Rather than attempting to generalize these accounts to all fat mothers in the United States, I have approached these interviews, and subsequent writing, with the intention of sharing the stories of *these* specific mothers (Harrison 2018). This method combats the "headless fatty" phenomenon, which was first named by Charlotte Cooper to

describe the way fat people are represented, talked about, and understood as a social problem (Cooper 2007). News stories about obesity feature b-roll footage of beheaded-by-camera angle fat bodies walking down the street as a commentator lists off whatever scary new statistic has come out of obesity research. We are 'the obese' and the faceless 'obesity epidemic' but we are never people with thoughts, feelings, or value. A google image search of 'obesity' and 'fat' return photos of bellies, faceless cartoons, skin rolls, and other *parts* of the whole. By including long form quotes I attempt to not only avoid turning these mothers into more headless fatties but to humanize people who are so often the victims of dissecting research (Harrison 2018).

Each of the mothers I spoke with had a different entrance into motherhood that impacted them deeply both in the moment and in the years since. The importance of these experiences cannot be overstated. For many mothers, the process of becoming mothers has continued to shape their day to day mothering, identity, and relationship with their bodies even ten years later. The following chapters present patterns seen across these mothers' stories, flowing in chronological order of the process of becoming a mother. Let us start at the beginning.

CHAPTER 4: BECOMING MOTHERS

> The narrative is that you can't be a parent when you're fat. It will be impossible to get pregnant and carry to term when you're fat. So I never really allowed myself to fully understand what it was going to feel like when I became a mother because I felt like I didn't want to get my hopes up.
>
> *-Emily, a single mother of one*

As evident from Emily's quote, fat women often hear that they cannot become mothers. This narrative–perpetuated by medical providers, friends, family members, and partners–influences the ways in which fat women imagine their futures. Many women, like Emily, internalize these fatphobic messages and, consequently, do not allow themselves to imagine futures they may want because they anticipate negative ones. Mothers shared their experiences of entering motherhood from seeking fertility treatment, unexpected conception, and adoption. I will begin with fertility treatment.

Fertility Treatment

Seven of the mothers I spoke with discussed seeking fertility care. Most of those mothers found that being fat restricted their access to fertility care. In fact, the simple act of being a fat patient was challenging. The BMI was often a standalone test when speaking to fertility clinics (as also found by Turner-McGrievy and Grant, 2019). Josephine, a single mother of two, said, "I encountered a fuck ton of fat discrimination when trying to conceive. I had several IVF clinics reject me because my BMI was too high. It was really devastating". Considering Josephine's experience, it seems evident that these institutions were using a constructed metric to decide

which women *should* have the opportunity to become mothers–and fat mothers were excluded. Several clinics she contacted required a statement of health from her primary care doctor to prove she was 'healthy' enough to undergo fertility treatment. Josephine recalled that this statement was required specifically because of her weight.

Mothers understood that BMI was an important metric, even for the initial appointment. For instance, Kate said she knew she had to be explicit about her weight up front with the IVF clinic prior to her first appointment to make sure she would be accepted as a patient. While the clinic assured her it would not be a problem, the individual doctor she saw had a different stance.

> He was incredibly fatphobic and said some incredibly painful things to me. I wasn't able to get up onto the exam table but he said "it doesn't matter, the exam table can't hold you". And I'm like, well then you need different exam tables. There are just so many microaggressions around being fat. He also said there might be challenges in terms of inserting the sperm because of the way that my belly pushes down on my uterus. It just does not make sense from an anatomical, physiological sense. I got the impression that he did not want to see me as a patient and was doing his best to encourage me to not be seen by him. But, I was stuck with him because I had an HMO and that was the provider that was covered…We tried Clomid[13]. He told me I could only be on Clomid for two cycles because at my weight my body would start to reject it, which again, is not true. What it comes down to with fertility clinics, they're really worried about their success rates. And they view fat people as unsuccessful. And so by taking me on, it was going to screw up his rates…It was a really rough year, we just kind

[13] Clomid is a brand-name of the fertility drug clomiphene. This drug works by increasing the hormones needed for ovulation.

> of went through it the whole time…The nurses always made comments about how hard it was to draw my blood because of my arm. They didn't want to have to try hard to get what they needed.

Here, Kate felt like the doctor's success rate was more important than her access to fertility care, which led to feelings of inadequacy and shame. In blaming unsuccessful attempts on fatness, Kate's 'failure' to conceive is not just a lack of pregnancy but a validation of anti-fat beliefs about fat pregnancy.

Further, Kate's quote demonstrates how a healthcare provider's anti-fat attitudes and beliefs can impact their medical practice, creating discriminatory and unjust practices that harm and marginalize patients based on their weight (Phelan et al 2015). Not only was Kate unable to safely use the exam table, her doctor openly dismissed this fact as a nonissue. The implications of a doctor's office not having exam tables that can safely bear the weight of fat patients can lead to discrimination, medical neglect, physical harm, and emotional distress (Kukielka 2020). Even though Kate's doctor did not explicitly tell her she was not welcome in the space, both the physical space and interpersonal interactions signaled to Kate a very clear message: she was not welcome. It is important for healthcare providers to ensure that their equipment is designed to accommodate patients of all sizes in order to provide a welcoming and inclusive environment for all patients and facilitate harm reduction (Kukielka 2020).

After this experience, Kate and her partner took a break from trying to conceive. It was taking a significant toll on her emotional wellbeing and was financially draining. When they decided to try again, their insurance had changed, offering Kate the opportunity to seek different care.

> By this point, I had a lot of internalized guilt and sadness. I kept thinking that this was my fault- it was my body keeping us from having a baby. Even so, I still wanted to have a baby so we went to another clinic. I had to call around several times to find a clinic that would see me because of the weight limits in IVF. There was one clinic where the gowns didn't fit and the ultrasound tech was openly annoyed about having to do more work in my vaginal ultrasound but it wasn't as bad as the first doctor.

This quote from Kate shows the ways in which the fat mothers I spoke with have become used to and internalized anti-fat interactions. Kate's comment, "it was my body," demonstrates how providers' anti-fat rhetoric encourages women to accept personal responsibility for their inability to conceive naturally. Additionally, Kate had developed significant feelings of shame, corroborating Thomson et al.'s (2013) claim that shame has a negative effect on maternal identity.

> Even so, I ended up looking for a new doctor. The first question that she asked me was, 'where are you going to deliver when you're pregnant?'I was so thrown off by her confidence in me. I will never forget that because it was just so matter of fact. I didn't even understand her question because I was like, 'wait, what are you talking about? I'm not pregnant!'. It was surreal. I think I had to sign some sort of waiver saying that because I was fat the outcomes might be different but it was never a conversation of me needing to lose weight. She framed it as, it's not a matter of 'if', it's a matter of 'when'... I ended up having to do a bunch of different surgeries and procedures in order to have a baby. Then, after two rounds I got pregnant. And now I have my son.

The simple (or not so simple) act of having her doctor believe in her caught Kate off guard. Kate was not used to being treated with respect and professionalism by healthcare providers due to her weight. That Kate had to sign a weight-based waiver shows there is still room to grow in ensuring equal access to assistive reproductive technology. The waiver also continues the pathologization of fat as a medical barrier (Parker and Pause 2018), but the doctor's supportive and respectful treatment went a long way in reducing Kate's feelings of guilt and shame. This shows that even if some institutions require specific weight-based policies, interpersonal interactions and care from medical providers are crucial in extending equitable care for fat patients (Puhl and Heuer 2009).

Other mothers faced similar weight limit barriers for IVF and Clomid access. After being unable to conceive without assistance, Susan, a married mother of one, started seeking medical care but was met with less than helpful advice.

> I started trying to get pregnant and, you know, went through a lot of doctors who were like, 'whoa, whoa, have you considered losing weight?' Like, oh my god, I was in my 30s. I had 25 years of considering losing weight and trying all kinds of diets. What I needed was fertility treatments!

Susan's quote suggests the medical community often assumes that weight loss is the solution to fertility issues without taking into account individual circumstances or addressing the root causes of infertility (Sole-Smith 2019). However, it also shows Susan was able to recognize that what she needed was not weight loss but fertility treatments, showing her success in recognizing the systemic bias in order to advocate for her own health and fertility success.

Even when mothers were able to meet the weight loss goals and prescribed weight loss regimens doctors would keep asking mothers to lose more without providing reproductive

assistance. LaMarre et al. (2020) discuss how refusing access to care without first engaging in weight loss leads to emotional and physiological distress and potentially physical complications. The mother's weight, not reproductive needs, became the focus of their appointments. Some mothers reported being denied access to medication that is meant to facilitate conception. For example, Hayley, a married mother of one, who was considered to be of advanced maternal age[14], felt immense pressure to get pregnant as soon as possible.

> I did everything to get pregnant. I lost 60 pounds, tried acupuncture, anything you could think of and everything they asked of me. But it wasn't enough and every single doctor I spoke to kept moving the goalposts. They'd say, 'oh, I see you lost a few pounds, you need to lose 10 more before I can give you Clomid'. This happened four times before I just gave up. So I had a friend, a regular sized person, trying to get pregnant and she had been prescribed Clomid for her infertility. So, she gave me some of hers and I got pregnant immediately. Like literally immediately. That's all I needed. We tried for three years and it was so frustrating because anyone could have helped us.

Hayley tried everything her doctors suggested, including losing a significant amount of weight, in order to conceive but she was unsuccessful until using Clomid. The doctor tied Hayley's access to Clomid to weight loss, and as such the refusal to prescribe it was related to weight stigma. Hayley expressed concern before sharing this story with me: in the United States it is

[14] Advanced maternal age is widely categorized as 35 years or older at time of delivery; however, the Committee on Clinical Consensus- Obstetrics of the American College of Obstetricians and Gynecologists notes that this is an arbitrary number and some age related effects don't begin occurring until 40 years of age (American College of Obstetricians and Gynecologists 2022).

illegal to take medication prescribed to someone else. Mothers, then, assumed control of the situation to help facilitate conception–a practice that was successful for Hayley, but could have also been dangerous and highlights the need for more inclusive and accessible health care. Moreover, the time that Hayley lost to trying to conceive, three years, is significant. This time frame can be especially critical for women who are considered to be of advanced maternal age. This delay could have made it even more challenging for her to conceive or could have meant she required more invasive fertility treatments.

Josephine was also considered of advanced maternal age as she went through the fertility process, but her age was compounded by other health issues –which hindered conception– and went undiagnosed and undetected while her doctors focused on weight. It took six years of trying to conceive via IUI and IVF to find out she had a disease impacting her uterus and fertility- it was not her weight at all.

> I felt distinctly like an outlier. You know, I would be the only fat woman in the waiting rooms at these clinics. You don't just see a doctor, you see a whole team of nurses and schedulers and staff. And each of them are a fresh opportunity for someone to minimize your struggle and make passive aggressive comments about your weight… they would blame my miscarriages on my weight. I had fibroids and repeatedly doctors would tell me they would be able to visualize my fibroids better if I was thinner and that my weight was the reason I was not able to successfully carry to term. It was never the case, by the way, I finally had to have an emergency hysterectomy because of a disease in my uterus.

Effectively, doctors' ideologies related to fat bodies denied Josephine the experience of having a biological child on her own–which perpetuated a eugenicist agenda that seeks to control

who can reproduce and who cannot based on certain physical characteristics (Sole-Smith 2019; Strings 2019). Further, Josephine's response shows a repeated, consistent level of anti-fat microaggressions as she moved through the process of trying to conceive (Munro 2017). Through Josephine's comment, "a fresh opportunity for someone to minimize your struggle," it becomes increasingly clear how healthcare providers viewed her fatness as a disease. Indeed, they were unable to look past her weight–and their own biases–to detect and diagnose the health complications she was suffering from, resulting in an emergency hysterectomy. Such a singular focus on Josephine's weight negatively impacted her health and, arguably, prevented her from becoming a mother in the way in which she desired. As a result of these experiences, Josephine pursued motherhood via adoption and surrogacy.

Adoption

Some people look to adopt when they want to expand their families. Adoption happens in several different ways- sometimes through state or government agencies, and sometimes through private organizations. Each agency sets its own criterion for adoption, through which they construct the ideal parent. Unfortunately, weight can factor into an agency's decision to varying degrees. Adoption as a process varies by country and by private or public agency (Pösö and Skivenes 2021). Due to this, it is hard to pinpoint specific weight limits on adoption in general. However, there are plenty of examples that demonstrate weight stigma plays a role in determining who deserves to parent through adoption. For example, In 2009, a couple was turned down for adoption based on the husband's BMI alone, as he was 'at risk' for illness and death (Carter 2009). While the family was told plainly the reason for this decision, I suspect this occurs at a much higher frequency than is recorded as many families are probably not explicitly told this

and if they were, they might experience extreme shame. Pollock (2019) wrote about the automatic 'no' given to fat people attempting to adopt from the Tulsa child and family agency, citing the parent's potential future health problems that may impact the fat applicant's parenting. Though health is not static nor guaranteed for any person, fat people are assumed to be on the road to illness and disability compounding anti-fatness with ableism. A good example of this is the U.S. based adoption agency, *Lifetime Adoption,* which features a page on their website detailing the reason "obese" adopters may be unattractive to birth mothers. They note that birth mothers fear there is risk of an early death among fat adopters and thus increases the threat of instability for the adoptee (Caldwell 2022). Were mothers in this study successfully able to adopt, even as fat women? Let's turn back to Josephine.

After six years of trying to conceive and eventually undergoing an emergency hysterectomy, Josephine sought out adoption through a formal adoption agency as an option to start her family. At first she looked into international adoption but found that most countries had BMI limits for adoption applicants–again reflecting intersecting ableist and anti-fat biases. Then, she began looking into domestic adoption.

> I had been to a couple of agencies and finally found one that was really wonderful, they weren't fatphobic. But they did tell me that because I was single, I did all of this as a single woman, they said it would take upwards of five years for someone to pick me…I went through the drought because I reasoned, and rightfully so, that there was enough need for fost-adopt families that they wouldn't discriminate, you know?

Fost-adopt refers to the process of becoming a foster parent with the intention to adopt a child out of the U.S. foster care system (Strom 1992). Josephine anticipated anti-fat discrimination in

the domestic adoption process and accepted it as a given- something she would have to push through in order to become a mother. This exemplifies the pervasiveness, or everydayness of anti-fat bias mothers discussed with me. She continued,

> I went through the whole process and met some folks in the fost-adopt class. We became really good friends. I watched a couple of them go through placements and I realized that as a person who had been trying to conceive for, at this point, years, I didn't think I had the heart to have a placement taken away from me…I decided to just make an adoption page on Facebook. I did all the things they do in the adoption agencies where you make a little book to show mothers with pictures of my family, who I am, that kind of stuff, just on Facebook. A friend of a friend reached out to me that way and asked if I was interested in her baby being placed with me. She was 36 weeks pregnant at the time when she reached out to me, so I had like four weeks notice! We had a really wonderful connection. I later found out that one of the reasons she felt such a warmth for me and bonded with me was because I reminded her of her mother who was also fat. So she placed me with this baby because I felt familiar and motherly and nurturing to her.

This was incredibly special for Josephine because she had, and continues to, receive messages from her family and friends that she is unfit to be a mother because of her weight. Even though Josephine reflected positively on the choice her child's birth mother made, it is worth mentioning that the stereotype of the maternal fat woman was at play, wherein Josephine's body sent a message about what kind of mother she would be. In the short term, it had a positive outcome for Josephine, but in the long term, this kind of stereotype is harmful. Josephine's quote highlights the intersecting challenges that single, fat women face in the adoption process. The

adoption agencies' policies and procedures reflect the societal norms and values that prioritize certain characteristics, such as being young, thin, and married, as ideal for parenthood. Caldwell (2022) encourages fat potential adoptive parents to highlight aspects of their lives and personalities in a way that draws attention away from their fat bodies. Josephine perceived the long wait time for single adoptive parents to be discriminatory.

While Josephine was successful in her quest to adopt, it is important to note that her success followed a pathway of denial and resistance. Her ability to recognize that her body may prevent her from adopting a child through formal avenues meant that she had to make a choice–accept this as another form of fat inequality or resist by forging her own pathway using social media. Even though the birth mother identified Jospehine as a fat woman, she also acknowledged that fat mothers are good mothers–which is evident through her decision to entrust Josephine with her own child.

Pregnancy

Feminist scholars have argued that through medicalization, power is taken from pregnant mothers and transferred to medical professionals (Neiterman 2013). Mothers who refuse to comply, or are unable to comply, with the hyper-surveillance of medicalized mothering are framed as ‘bad mothers’ (Ioannoni 2017). This process is also incredibly racialized (Bridges 2008). In order to protect themselves and keep their hopes of motherhood alive, mothers immerse themselves in medical searches; thus, they become quasi-medical experts in an attempt to control their experience within the healthcare system. Through this “Google MD” process,

mothers are protecting themselves against anti-fat institutional actors as mothers feel doctors are policing their bodies more than they are ensuring their health and safety.

More than an act of resistance on the mothers parts it is truly a matter of life and death. Medicalization also impacts the hope mothers allow themselves to feel about the process of pregnancy and becoming mothers. In what should be a time of happiness, mothers are shrouded in fear and anxiety. For Emily, a single mother of one, a lifetime of anti-fat rhetoric from doctors and friends impacted her experience of pregnancy and the first year after her child's birth.

> I had really bad postpartum depression and anxiety. I feel like I kind of dissociated from being a mother for, God, the first year. I always wanted to have a baby. I wanted to have a ton of babies. But I didn't know what I was doing and I had focused on the goal for so long that I kind of forgot what it would actually look like when I was actually a mom. I think some of that was because I had to do IVF. But then, also, a lot of it was because I was fat.

Emily's child was five years old when we spoke. She talked about how her experience of parenting is now in a more relaxed place where she is enjoying time spent with her child, but this wasn't the case for the first three years of her child's life. Emily explained that because she never "allowed" herself to really think about what it was going to feel like to be a mom, when it happened she was completely overwhelmed. In recounting the first several years of her child's life, Emily described her experience as "a means to an end, making sure that he was clothed and fed." As she recounted those first years, Emily discussed how the narrative she kept encountering when it came to fat parenting was one of impossibility: "you can't be a parent when you're fat, you'll have a hard time being pregnant, or even you can't get pregnant when you're fat." Emily's experience with anti-fat messages had a significant impact on her mental health and ability to be

a present mother for her child. Emily felt disconnected from her role as a mother during the first year of her child's life, and she struggled to feel completely at ease for two more years after that. Emily's experience shows how internalized fatphobia negatively impacts fat parenthood, sometimes for years.

Susan echoed similar sentiments as the fear she experienced during pregnancy was paralyzing.

> I had this fear of loss that was so intense that at one point, I met up with my best friend when I was 23 or 24 weeks along, almost to the point of viability where if I had her she would survive, even if very premature. But, my friend was like, 'buy a fucking outfit for your kid because you have nothing!' I refused to buy anything in case we lost the pregnancy.

While some level of prenatal maternal anxiety is expected, the levels of anxiety brought up by several mothers was exceedingly high. The experiences Susan had with medical care providers and her own self-esteem regarding her weight led to her prenatal anxiety skyrocketing. Even though Susan was in the process of becoming a mother, the anticipation of a negative outcome was so strong it stopped her from preparing for the arrival of her child at all. The future she desperately wanted was on the horizon but remained clouded by fear.

In a large-scale review of pre- and postnatal maternal anxiety, Correia and Linhares (2007) found that mothers who experienced obstetric problems (medical and social) experienced high levels of anxiety. For Emily, this contributed to severe postpartum depression and anxiety that lasted for several years after the birth of her child. Heightened anxiety led to an increased health risk for both mothers and fetuses. Further, several studies reviewed by Correia and Linhares (2007) found that children were negatively impacted developmentally years after birth

in cases of high maternal anxiety. This study revealed elevated levels of prenatal anxiety and depression before and after childbirth led to a two or threefold increase in the average incidence of behavioral and emotional difficulties among children by the time they turned four. The mothers I spoke with consistently brought up feeling anxious after and between appointments where they felt stigmatized. Therefore, anti-fat rhetoric and weight stigma can produce long-lasting effects on both mothers and children.

Indeed, more than half of the mothers discussed how these anxieties showed up in their day to day lives and impacted how they moved through the world. Susan's anxiety was twofold: first, that her fat body was to blame for repeated losses and second, that if she were able to get pregnant, her fatness would negatively impact her ability to be a "good" mom–which would influence how her child would view her. Susan brought two items to share during her second interview. One of the items was a necklace she was wearing during her first interview.

> This is a unakite[15] necklace, unakite is a transformation stone…I read about how it helps with transformation, strengthens your heart, bridges the gap between the shit you need to let go of and the stuff that's coming or going to fill your heart space with better things. So I thought, 'oh, this seems like a really good thing to have for pregnancy and the journey I had to get here!'...it made me really think of this transformation into motherhood and how I could be the best mom to my child… I wasn't going to disappoint her, I wasn't going to humiliate her at school drop off because I was a big fat mess. I finally realized she was not going to look at me and go, 'what a big fat lady I have for a mom!' or 'what a trainwreck', or 'look at that gray hair, she is so much older than all my other friends' moms' or

[15] Unakite is a type of granite characterized by pink and green tones popularly used as a decorative gemstone (King, 2022).

> whatever. She is just going to look at me with love… this baby is not going to notice a fucking thing except that I'm her person. It helped me to settle into this idea of not being embarrassed to be who I was in a way that really helped me settle into motherhood.

Susan's necklace is another example of these mothers finding joy and resisting the anti-fat narrative consistently pushed onto them. It also highlights the fact that her 'transformation' into being a mother happened before her child was born, and indeed even before becoming pregnant Susan was worried about her fatness impacting her motherhood. This underlines the need to understand motherhood as a throughline of connected events that have no clear boundaries.

Six of the mothers brought up a previous diagnosis of polycystic ovary syndrome (PCOS) as the reason given for their current or possible fertility issues (though several more had received this diagnosis outside of a connection to fertility issues). This is a commonly diagnosed hormonal disorder where ovaries produce a higher than average amount of androgens (male sex hormones), which can result in a cluster of symptoms including: cystic ovaries, excess body hair, weight gain, acne, irregular periods (Grace 2010; Bussell 2013). PCOS can impact fertility though it does not preclude every person from conceiving (Grace 2010). Allana, a single mother of one, has PCOS and discussed her unplanned, naturally conceived pregnancy.

> People always equate being overweight with being unhealthy. If you're a plus size woman trying to conceive and you have a hard time, everyone automatically assumes it's because of your weight! I've always been plus sized and I got pregnant so easily, it wasn't even planned. When I had my testing done for PCOS, we discussed my hormone levels and they were all in the normal positive range. I am fat but there is nothing about my body that shows it should be difficult for me

> to get pregnant again if I were to choose to. Even though there are thousands of other things besides weight that could impact someone's fertility, those are never discussed. I'm glad the way overweight people are treated by doctors is talked about more, but no one talks about overweight motherhood and pregnancy.

When we first began discussing Allana's pregnancy, she told me anti-fat messages from her doctors did not impact her deeply. However, as we continued with the interview, her tone shifted to one that suggested that these messages had, in fact, affected her more than she initially let on. I found this to be true with several mothers I spoke with- anti-fat beliefs are so hegemonic that Allana (and others) had not stopped to see how they might be impacting her psychologically and emotionally (Abrams 2022).

> [The doctor] did say at the beginning, 'your BMI is here, if you gain more than X number of pounds and your BMI increases to X number, I can't deliver locally. You'll have to go to [major city two hours away] as a high risk delivery'. So I guess he did hold that over me….or I guess the weight of that. And I think it wasn't explicitly said that my pregnancy was going to be difficult but it was implied. My pregnancy was difficult but it had nothing to do with my weight! I was just sick- I threw up so much I probably should have lost weight. I don't think it impacted me to an extreme point but the experience did impact the way I think about potential future pregnancies and worrying that if I were to get pregnant again would I need to change things about my body? Would I be unhealthy? Would I not be able to do it safely or whatever?

From Allana's statement, it is evident that at least some medical institutions are codifying fat maternal bodies as high risk and "out of bounds." Davidson and Lewin (2018) write that the

narratives around who should, and is fit to, be pregnant is "deeply rooted aggression" towards fat people, veiled by concerns about health (p. 45). They argue that this is a moral framing, and not one based in medicine. In an anti-fat society, "benign fatness," especially in reproduction, is impossible (p. 46). The doctor suggested that her body was too large to be accommodated by the local hospital based on the policies in place. Even though Allana's local hospital had a maternity ward, her doctor requested a transfer. Allana interpreted this as her body being a significant liability for the local hospital even before she was in labor. She internalized this and became worried she would be unable to have healthy pregnancies in the future because of her weight alone. Most individual doctors do not control hospital policies and as such are required to follow institutional guidelines for patient care. Even though this is the case, the mothers reported feelings of interpersonal shame accompanying the decisions around their care. These negative interactions may also contribute to fat women having fewer children because of their care providers' focus on fat pregnancy as a risk. Addressing both institutional biased policies *and* individual provider's biases is crucial in reducing inequality for fat mothers.

Looking the Part

For some, pregnancy is a time of joy shared with family and friends. It is also a time of hope for the future. We assume we know when someone is pregnant based on an abdominal bump (or lack thereof). A round belly assumed to be carrying a fetus is a temporal, acceptable fat belly, whereas a fat belly that doesn't signal pregnancy is not (Nash 2012). It is in vogue for mothers to share 'bumpdates' on social media as their pregnancy progresses. A 'bumpdate' is typically a photograph showing a pregnant person sideways measuring the size of their baby bump. These are often taken at week intervals, and occasionally include references to the size of

the baby. For example, “30 week bumpdate! Baby is now the size of a cucumber!” Whether or not a person ‘shows’ during their pregnancy is impacted by a number of factors including where the baby sits in utero and the body shape of the pregnant person (Higuera 2020). For many fat mothers, their pregnancies never ‘show’. For Maria, a married mother of two young children, this dramatically impacted not only her experience of pregnancy, but her family's as well. While she was elated to be pregnant, she never felt like her pregnancy was acknowledged by others around her.

> I didn't really look pregnant. My husband had a hard time connecting with me for a long time because I didn't look pregnant. He finally talked to me about it and explained, ‘you know, I don't feel connected because I don't see it like I would with someone else’. So there was that. My family never brought it up but I could tell there was very little connection when I was pregnant because nobody really treated me like I was pregnant, they couldn’t see until I would remind them. It's discouraging to even go out in public and nobody notices.

I could tell Maria was deeply affected by her family’s lack of enthusiasm about her pregnancy. These microaggressions, social cues in the form of dismissals, led to feelings of isolation for Maria–and denied her the same celebratory feelings often experienced by thin mothers. Maria’s quote suggests that there are specific social roles and expectations that pregnant people are expected to fulfill, and failure to conform to these expectations can lead to discrepancies in treatment for fat mothers (Nash 2012). In Maria’s case, these social pressures came from within her own family. Further, these reactions and treatments shaped how Maria felt about her pregnancy both during it and years later.

In contrast, Amanda, a married mother of two, also discussed the feeling of being seen as a mother publicly and how that was deeply important to her experience of early motherhood.

> I bought this baby carrying wrap… it gave me a sense of pride when I was carrying my children. I would get powerful comments from strangers in line at the grocery store, they'd say things like "wow, they have the best seat in the house" or "they look so cozy!". It was such a different experience to being pregnant when no one could tell. Carrying them in the wrap was a way to showcase what I had done with my body by almost putting them on display.

Though her youngest child is now almost four years old and no longer able to use the wrap Amanda brought as her toy box item, Amanda has held on to it. When pregnant, she did not receive the same kind of positive messages from people in public. In order to attempt to reclaim this lost experience, Amanda literally wore her child to garner social responses. Allana, a single mother of one young child, spoke about how the images of motherhood we see in social media impacted her during and after pregnancy.

> If you have a skinny woman who is pregnant and she gains a lot of weight and it's a big baby, people are talking positively about her the whole time. Saying things like 'oh you can eat whatever you want,' 'look how big you are,' and it's all nice. But if you have a plus size woman in the same situation, the comments are so different. Then it's like, 'oh maybe you shouldn't eat so much', 'you need to be careful', 'you don't want to birth a 12 pound baby'. I constantly felt that happening to me, it was always implied I shouldn't do things [during pregnancy] because of my weight. I think I also get affected by social media. A lot of people I went to high school with are becoming parents now, and they post these picture

> perfect family photos online. They're all skinny, they can afford these professional photographers, they're wearing dresses, I don't know. I just see them and I'm like, 'oh, their motherhood is very different from my motherhood just based on their body.' You know?

Allana's story highlights the intersection of class and weight (Ciciurkaite and Perry 2017): her pregnancy looked different from thin, wealthy mothers. The curated image of picture-perfect motherhood presented on social media also speaks to the ways in which class can impact people's ability to access resources and support during pregnancy and motherhood. Interestingly, this may also impact a mother's ability to 'be there' both in the moment and in the future. Professional photos may also have the capacity to serve as a tangible reminder of love and commitment to 'being there' for one's family and children, which could help to strengthen family bonds, creating a sense of security and stability. While financial privilege is not the only factor that contributes to a mother's ability to be present and engaged with her children, it can certainly play a role in creating opportunities for meaningful connection and lasting memories.

Allana's account also underlines the ways in which thinness is the ideal body type and as such thin women are rewarded with positive comments and praise, even when they gain weight during pregnancy as pregnancy is understood as a 'temporary' fatness (Nash 2012). However, for fat mothers, any weight gain at all is met with criticism and shame implying they are putting their health and the health of their baby at risk.

People often feel comfortable commenting on pregnant people's bodies whether or not they are familiar with them. Questions like, 'when are you due?' and 'is this your first?' are considered polite small talk. When your body does not fit the mold of what pregnancy 'looks' like, the experience is vastly different and can come with more than just uncomfortable

conversations with strangers. For example, even though she was not under pressure from her doctor while pregnant, the idea of what a pregnant person *should* look like weighed heavily on Jessi, a married mother of two.

> Right after I found out I was pregnant, a four-year-old student asked me why I was so fat. These kids will just ask you anything, they have no filters. "Why are you so big?", "Why is your chin so squishy?", "Why does your belly hang down so much?" They really affect me, specifically with motherhood.

The students in Jessi's care as a preschool teacher were not yet of elementary school age, but they were already socialized into seeing and talking about body size. That such young children already know which bodies are 'not quite right' ("big", "squishy", hanging belly), highlights the insidious nature of weight stigma and how it can be internalized at a very young age. Moreover, it also underscores the importance of addressing weight stigma in a variety of settings, including schools, to prevent its perpetuation across generations. It is important for workplaces, including schools, to implement policies and practices that promote equity, diversity, and inclusion, and that address weight stigma and discrimination. This includes educating students, teachers, and staff about the harmful effects of weight stigma, and creating safe and welcoming spaces for all individuals, regardless of their body size.

Further, these kinds of interactions stuck with Jessi, who still blames herself for her twins' early birth.

> I don't know why my twins were born early, I never got a definite answer. But sometimes in my mind, I feel like it was my fault because I was overweight when I got pregnant…I feel like I failed my kids. I went through a terrible time after they were born thinking their [stay in the Neonatal Intensive Care Unit] was my

> fault. My body failed me and had I been a smaller size or weighed less or whatever, they wouldn't have had to go through what they went through.

Jessi expressed feelings of guilt and failure, believing that she could have prevented her twins' premature birth and NICU stay if she had been smaller or weighed less. She also acknowledges the trauma her children endured but does not acknowledge she also experienced significant trauma. Internalized fatphobia, then, may lead mothers to prioritize the perceived comfort of others over their own needs and feelings, including pain and trauma.This self-blame and self-criticism was damaging to Jessi's self esteem and feelings about her ability as a mother from the beginning. It is possible that if Jessi had received support and more information about her pregnancy, including associated expectations of twin pregnancies, she may have been better equipped to handle the stress and uncertainty that arose when her twins were born prematurely. Instead, Jessi's internalized anti-fatness increased.

The idea of what a pregnant person *should* look like carried into doctors' offices and medical examinations (Canipe 2012). A number of mothers faced shame, discrimination, increased surveillance, and physical violence over the course of their pregnancies. Once she became pregnant, Hayley had to see a new rotation of doctors for pregnancy care. Each time she went for a check up they would shame her for her weight, disregarding the fact that she had lost a significant amount of weight prior to becoming pregnant on doctors' orders.

> It was always the same discussion of how I was higher risk because of my weight. I think it was for insurance purposes. It was like, I know, I'm fat! I know! Every single doctor I saw, and they always rotated, was like, 'hey, you're really, really, severely morbidly obese, you have to get this under control'. It's like, well if you'd look at my chart you could see I lost a lot of weight to get here.

Not only was it emotionally taxing for Hayley to continue to have these conversations with doctors who were harsh and insensitive, but she began to feel like there was no way for her to win and have a successful, happy pregnancy. In essence, the doctors' fixation on her weight, coupled with the fact that they did not acknowledge her pre-pregnancy weight loss, denied Hayley the right to simply focus on the experience of pregnancy.

Loss and Grief

A few of the mothers experienced miscarriages along the way to becoming a mother. This is often a traumatic experience in and of itself, but these mothers were met with callous responses from their medical teams who blamed the losses on their fat bodies. Susan spent several years trying to conceive without fertility treatments but was unsuccessful. By the time she and her husband were able to pay for fertility treatments through insurance she was in her late 30s, which as aforementioned is considered a medically advanced maternal age. In the process of undergoing each round of hormonal fertility treatments, and to the disappointment of her doctors, Susan gained weight and suffered five miscarriages. Her doctor then suggested weight loss surgery before continuing with fertility treatments but cautioned she would need to wait at least 18 months after the surgery to allow her body time to heal.

> I was 35 years old! I don't want to wait a year and a half before I can even try to get pregnant, I wanted to have a baby years ago. So I went on a crash diet to lose weight. It wasn't awesome to say the least. The weight loss didn't last but they wanted me to be whatever number on the scale and so I did it in a very unhealthy way. I'd never do that again.

Several other mothers corroborated this feeling that numbers and metrics were the focus of their medical care providers rather than them as people and their health. Susan's five losses included an ectopic pregnancy and a subchorionic hematoma induced late term miscarriage.

> I felt like I did it to myself. So many people kept saying 'well this happens more to overweight people' after I had an ectopic pregnancy. Great. Cool. Cool. Cool. Cool. Thank you so much for that very helpful information. You know, they're not kind…I really felt like my job as a mother is to make sure my kid is ok and I had failed fucking miserably by having losses that were somehow weight related.

From this quote, it is evident that Susan has internalized fatphobia and blames herself for her miscarriages. When she was pregnant again just a few months later, she was put on bed rest for a second subchorionic hematoma. In a review of fourteen studies on weight and pregnancy complications, Koning et al. (2012) found that higher weights causing ectopic pregnancies is "presumed" out of commonly held anti-fat biases, not scientific evidence (p. 457). Further, Cai et al. (2021) found that lower weight patients had the highest instances of ectopic pregnancies, and that there was not a significant difference in outcome between 'normal' and 'obese' patients. Furthermore, regardless of whether or not there is a correlation between weight and these negative pregnancy outcomes, the shame Susan endured after her losses significantly impacted her self-worth. These losses, and the subsequent responses to them, also increased her fear and anxiety levels dramatically. She was able to successfully carry her last pregnancy to term but was under significant medical observation.

> They kept saying, 'you have to get these tests!' and I was like, of course, I have to get these tests because I didn't want anything to happen to that pregnancy. And thank goodness nothing happened but a lot of those tests probably could have

> been avoided. I felt like I was at the mercy of these medical people saying 'we have to do this', so I did… I couldn't stand up to them because I was in a place of fear. You know, it's hard when you're trying to research things as somebody who doesn't have a medical degree, and you're googling things, and you're going on, like pregnancy groups. And those places are horrible!

The extra tests Susan underwent were added (and unnecessary) expenses both financially and emotionally–which made Susan feel the doctors kept their focus on her fat body, rather than her baby. Though some extra tests may have been administered to thin mothers, the sheer number Susan underwent could reflect decisions that were made in anti-fat bias.

Mothers developed strategies to deal with pregnancy losses and/or to protect fetuses. For instance, Maria brought a necklace to contribute to the Toy Box. She got this necklace during her first pregnancy. The necklace demonstrates how she dealt with a misscarriage and hoped for pregnancy success.

> When I lost my first pregnancy, it was really rough on me. I had to find a way to get back to normal. There are three charms here. I'm Catholic, so this [points to the charm] is the same person you pray to when you've had miscarriages and you want children, or any fertility issues. After the miscarriage I added this one, it says "Mommy to an Angel". The saints are St. Gerard, St. Gianna Beretta Molla, and St. Caterina Da Siena. They're all saints that have to do with becoming a mother, fertility, and watching over a growing fetus…It was the start of motherhood for me, when I lost the first one. I was still a mom, I had a baby…praying to keep them safe and with me through my pregnancies helped me

> feel more comfortable. I was able to take things day by day instead of living in constant fear of what could happen.

The necklace brought solace and reassurance in an otherwise deeply stressful time. Simply anticipating a fatphobic experience or confrontation took a physical and mental toll on most of the mothers I spoke with. Despite tremendous pressure, these mothers found a myriad of ways to manage the emotional toll of their experiences.

Birth and Postpartum

For as long as she could remember, Maria had been told she would be unable to get pregnant and have a successful pregnancy because of her weight. Even after she became a nurse with medical expertise she received pushback. Despite her conviction that fat people can carry successfully, after her first pregnancy resulted in miscarriage the anti-fat messages began to take a deeper toll on her. Ultimately, Maria had two successful pregnancies. But as evident by her following quote, weight stigma created significant anxiety and worry over not only successful pregnancies, but her own autonomy in the birthing process.

> I know it's not impossible [to have a safe vaginal birth]. But you know, sometimes doctors don't care. Even when I delivered my kids, I told my husband before it was time, “don’t let them pressure us into a C-section! It doesn’t have to happen that way!”

Maria preemptively prepared not only herself, but her husband, for potentially unnecessary invasive care because of her weight. Again, rather than focusing on having a successful birth and a healthy baby, Maria’s experience was overshadowed by weight stigma.

> I knew pushing out a child had nothing to do with my weight. I told him, “They’re going to scare you. I need you to stand by me with the decisions I have

> made because I am not going to do anything to hurt our kids. They may scare you into thinking that my body can't do it". I had to be really prepared with what I wanted. The medical field has this taboo against plus size women having kids and it's very unfair.

Despite her medical experience and knowledge, Maria still had to prepare both herself and her husband for the inevitable anti-fatness she knew she would face at her deliveries. How many mothers must endure the trauma of a c-section because they lack medical knowledge or simply feel they need to defer to medical authorities? There are a number of factors that influence whether or not a c-section is performed, though they are not all strictly medical factors (Oster and McClelland 2019). The current system provides a financial motivation to conduct c-sections, which can be decisive in situations where clinical judgment is uncertain (Oster and McClelland 2019).

While Nena, a married mother of one, had an incredibly supportive, weight-neutral OB for the majority of her pregnancy, in the last month leading up to her due date the OB switched his stance. She said,

> I was shocked because he's never brought up the weight issue but he did this time. His concern was that the baby was measuring over 10 pounds and they were worried I wouldn't be able to give birth to the baby naturally because I'm overweight. I had read all the studies, I knew this was total crap! So I said, 'No, I'm not willing to schedule a c-section!'

Interventions in otherwise unremarkable fat pregnancies (like pushing for c-sections) is not only happening at increasing rates but makes pregnancy less safe (Davidson and Lewin 2018). That Nena's doctor began warning her about a c-section birth a month before her due date is important

to highlight, as it reflects anticipation of a negative outcome based on Nena's weight and not how the pregnancy was progressing.

It is also encouraging to learn from these mothers that they were educating themselves on the necessity of c-section. This is a form of resistance among the mothers to maintain as much bodily autonomy as they could–which demonstrates that the mothers do not always defer to doctors and their ideologies. Nena remained adamant that she did not want to undergo a c-section if it was at all possible to avoid.

> The doctor warned me that the baby could get stuck in the birth canal because he was measuring over ten pounds. If this happens they sometimes have to dislocate the baby's shoulder. Doctors scare the shit out of you. Now I know that first time moms can easily go a week over a due date but I didn't know that then. I said no, I will not schedule a c-section, I wanted to try and let my body do what it's supposed to do. So I compromised with the doctor. I told him, if the baby doesn't come in five days I will come in and we can do an induction. Five days happened and the kid wasn't going anywhere and I was dilated at about nothing. I went to the hospital early in the morning and the nurse immediately wanted to do another ultrasound. She said that if we could get the ultrasound tech to measure anywhere under ten pounds we would have more wiggle room. As I'm lying there the tech asked, 'the last time you had an ultrasound,was he breech?'. I said, 'what??' but immediately all discussion of an induction went right out the window. I wish I had asked to see the ultrasounds. I know it sounds so paranoid but I feel like I really was pushed into the c-section. What I should have done was politely decline and left the hospital. He flipped once, he could flip again.

C-sections are being pushed more frequently across the board in the U.S. (Wolf 2018), but these stories show an increased pressure for fat mothers to undergo c-sections specifically because their bodies are deemed unfit for vaginal births. The CDC found that in 2020, c-sections accounted for nearly 32% of all live births in the United States. People considered 'underweight' made up roughly 20% of those while the highest weight individuals (classified as 'obesity class III') made up over 52% of all c-section births. As weight increased, the likelihood of a c-section increased across the board (Horon, 2021). Unfortunately this is what happened to Nena.

> He did flip again, he was head down when they got him out at 5 o'clock that night. All the nurses were asking the doctor, 'how does an 8 pound 4 ounce baby flip? How does this happen?'. They all called [child] Houdini because they're not supposed to just turn in there, but I guess with a certain percentage of babies this happens…So [child] was born eight pounds, four ounces, he was never even near ten pounds. I just knew he wasn't but ultrasounds aren't as accurate near the end of pregnancy because your stomach is so big. For plus size women the distortion is even worse. I had to have therapy after the c-section. It was super traumatic and overwhelming for me. I had nightmares for months and months after it. It was awful. I've done a lot of eye movement desensitization and reprocessing therapy on the experience so I don't get upset about it anymore. But I do feel like, sometimes I wonder if I had been a fitter mom, would they have given options? Would they have said, "let's try to turn the baby"? There were so many things they could have done but the c-section was on my doctor's mind. At least I didn't have to deliver at a special hospital.

Eye movement desensitization and reprocessing therapy (EMDR) is a structured therapeutic approach that involves a patient briefly focusing on their traumatic memory while experiencing bilateral stimulation, typically through eye movements (Shapiro 2017). This process has been associated with a reduction in the intensity of emotions and vividness of traumatic memories (Shapiro 2017). As a first time mom, Nena did not have the knowledge and confidence to say no to the doctors involved in her child's birth; thus, she deferred to authority. Not only did they skip over several options to flip the fetus, they used alarmist, terrifying examples of what could go wrong should she not comply with their wishes; thus, reinforcing the fact that fat mothers' autonomy is suspended in place of medical staff authority. The medical team in charge of Nena's care was influenced by anticipating her fatness as an automatic risk of disaster.

Several things happened during Nena's birth that may have led to the unnecessary c-section. First, Davidson and Lewin (2018) highlight the fact that "increased fetal monitoring does not improve outcomes for pregnant people or their babies and has negative impacts on labour, such as decreased mobility, [and] increased rates of Caesarean birth" (p. 53). Furthermore, they write:

> The American College of Gynecologists and Obstetricians (ACOG) has stated that it is more difficult to monitor the babies of fat pregnant people. This difficulty with the technology results in hospital staff placing greater restrictions on movement during labour, which is acknowledged by ACOG as a risk for Caesarean delivery…Pregnant people are warned that their dangerous bodies and dysfunctional labour warrant more Caesarean births, but failed technology, along with poor clinical expectations, may more likely be the culprit (p. 59).

It was clear during our discussion that even though Nena had spent significant time working through this experience, it was still a life changing trauma.

Although Nena also found the c-section to be traumatizing, she views her scar as a "badge of honor"--emblematic of her ushering in new life. In fact, one of the two Toy Box items Nena brought to discuss was a photograph of her c-section incision taken in the hospital right after surgery.

> When I had my c-section, obviously I'm a bigger girl and I can't see down there. When I got to my room I asked the nurse to take a picture of it for me. I couldn't believe how good it looked. I was expecting some massacre. When you have a c-section and wake up in recovery, there is this nurse pushing your body around and cleaning up blood. There is blood everywhere. It's like they just ran over you during the c-section. You see all of this and they're really relaxed about it. You're busy nursing your baby and have one nurse with you but then there is another nurse down there, and occasionally you notice them. She had these big ol' towels and she's wiping me. They're covered in liquid and blood, it's gross. I don't have anyone close to me who's ever had a c-section so I didn't know what to expect. That's why I asked her to take the picture of me. I was just amazed at my body. I've only been amazed at my body a few times in my life and this was probably the second time. I was like, you just got cut open end to end and somebody took out your baby, like damn, you know? Being a plus size mom, you're completely naked, completely exposed, and you have all these nurses helping you which is fantastic but you're still embarrassed. But it was this moment of, holy shit, I did that! But then considering all of the therapy I had to do related to having the

> c-section and having PTSD and waking up in cold sweats at night. I had to really mentally work through that. This picture became so important to me. It's almost my badge of honor. One of my goals, which is so funny, but one of my weight loss goals is I want to be able to look down and see my c-section scar. I know it sounds totally weird. I can't feel the area, it's totally numb, I can't feel any of the scar. It healed fantastically, I was so lucky. The scar gets rolled under my belly though, tucked up, and I really want to see it…I'm so glad I asked for the picture.

While the c-section surgery was deeply traumatic for Nena, the resulting scar is now a reminder of her strength and ability. The message given to nearly every mother who went through pregnancy and birth was that their body was unfit to have a natural delivery. Some were warned that their babies would be too large and would not fit through the birth canal.

At the same time, the mothers were told their bodies were unfit to recover from c-sections by nurses at the hospitals where they delivered. Nena's comment, "I was just amazed at my body," demonstrates that she did not anticipate a smooth recovery from surgery because of the anti-fat comments she had been hearing. Rather, she anticipated a "massacre" that would be hard to recover from. While it was emotionally hard for Nena, the physical healing was not. It does seem that the weight stigma Nena endured during her pregnancy and surgery led to the deeply difficult emotional recovery. That may have been avoided if she had received weight neutral care. Carla was warned, as Nena was, that because of the shape and size of her body, a c-section would automatically be accompanied by infection and complications.

> I had an emergency c-section. But you know, I healed well. I remember the physician that did the c-section, I did not like her afterwards. She was really shitty saying 'you have to keep this clean, because you're guaranteed an infection'. The

> incision was under my belly essentially, and she kept saying I had no choice and I was going to get an infection because of how my belly was. Fuck you! I can keep it clean! I think she was trying to scare me into paying close attention to it. We changed the dressings a bunch and my spouse helped me get through it. I recovered well and pretty quickly which was lucky because I had enough emotional turmoil during all of that. I don't know if I could have handled much more physical turmoil.

Carla's story reveals another truth: the mothers were frequently on the receiving end of anti-fat comments from those in charge of their care. While the hospital undoubtedly had policies on how to instruct patients in discharge wound care, a few mothers reported feelings of shame after such conversations, and attributed the negative interactions to anti-fat bias. The doctor's comment, "you're guaranteed an infection," is likely attributed to an assumption that Carla would have difficulty accessing the wound.

Fat bias does not simply determine how a mother will birth a baby, but also where. Allana and Brianne were told that they might have to deliver at special hospitals more than an hour away from their homes because of their size. Research shows that fat pregnant people are automatically characterized as high risk pregnancies that must be "controlled" (Lauridsen 2020: 759)--and hearing that they might have to give birth at a designated space for fat mothers demonstrates this control. This (potential) transition to a different hospital negatively impacted their birth experience. Teresa ultimately delivered at a special hospital she deemed 'the fat hospital',

> I shouldn't have to worry that the hospital bed I'm lying on can't support my weight or the weight of my husband sitting on it with me. If I were thin, that

wouldn’t even be a thought in my head. Even pull out couches and cots! I get that [hospital] space is small but a grown person should be able to comfortably sit with their spouse. Especially if I’m stuck living at the fat hospital! So there is a hospital and a birthing center, and if your BMI is over a certain number, you’re not allowed to deliver at the nice birthing center where everything is cushy, it's all pretty and cozy. It's cute! It is clearly where babies happen, it's exactly what you’d imagine for delivering babies. No, you have to go to the fat hospital and everyone mentions it all the time. Oh you’re delivering at [hospital name], they make it a point, like, yea that’s right! You’re too fat! The hospital rooms there are just not as nice and the whole experience is not nearly as luxurious and cushy. You don’t even get a choice. They're right across the street from each other so they couldn’t even argue that they were too far from a NICU. They’d just say that “fat people's anesthesia is so wildly different!” You’re literally across the street!! It sucked to see the pictures of my friends delivering and how nice their experience was versus how utilitarian mine was. I think some of the nurses try and make up for it a little bit but it's not the same. And to know it's not the same because you don’t even get to try delivering at the birthing center sucks. They say the reason is the risk of anesthesia for BMI over a certain amount. I encountered it here when I needed to have minor foot surgery. They wouldn’t let me do it at the surgery center because they said I was too fat for their anesthesiologist. But like, just make it so you can treat us. You know that fat women exist, you know that this is happening… [sighs] Everyone made such a big deal out of the fact that I had to go to the

> hospital. Even the things you take home after birth are different. It's….it's just very obvious what is happening.

Teresa's experience demonstrates how weight stigma permeates medical institutions and how that process impacts individual access to care, comfort, and dignity (Phelan et al. 2015). That a hospital, especially a 'fat hospital', doesn't have furniture designed to support fat bodies (literally and figuratively) highlights the structural barriers that fat people face in accessing appropriate medical care. Further, Teresa points out that these aren't issues that would concern thin mothers, though they take up significant space in her thoughts. While the 'normal' hospital experience is "luxurious and cushy", the "fat hospital" is drab and ready for catastrophe. Teresa did not have to read between the lines in this instance, the treatment she received was because she was fat. And the space design and accolades associated with giving birth were a reminder that she deserved something inferior to thin mothers' treatment.

Though the mothers detailed extensive warnings they received before and during pregnancy and childbirth, there was not the same level of surveillance and care once the babies were born. There was a noticeable shift in attention from mothers to their newborns, though this is not unique to just fat mothers. While it is important to monitor the babies, this often came at the expense of the mothers' emotional and physical health. To provide an example, Melissa, a married mother of one, brought a photograph that was taken a few days after the birth of her child to her second interview. It shows the baby's handprint imprinted on her chest. This is all illustrated through Melissa's extended account.

> After he was born, even before I left the hospital, I noticed I was starting to swell pretty aggressively. It was in my legs, which is where my chronic pain originated. So having swelling isn't necessarily weird for me. After I got home, I noticed my

toes were also getting really swollen. My parents had made some comments about it but I didn't notice because I was so focused on the baby. I didn't realize how bad it was until this picture, and this picture was taken nine days after he was born. I had been holding him on my chest, you can see my swollen neck, you can see my swollen lips. I thought I was just gaining weight. I was embarrassed. I had video called my parents that day and they said, 'you really need to call someone, something isn't right'. I called the hospital but they said well, this is a labor and delivery issue. When I called labor and delivery, they said, 'it's normal to eat more after you deliver. Maybe that's what it is.'. That didn't sound right to me so I called my OB who was the most amazing guy ever, never once made a fat comment any time I went in there. He was amazing. He said he needed to see me that same day. When I went in he sent me immediately to urgent care and warned me that I may be admitted to the hospital. I started to worry and thought, oh man, this is really not good. I didn't really understand what was going on at the time, though. So I took my brand new baby with me to urgent care to get evaluated for postpartum preeclampsia. I didn't realize until I got to the doctor's office that in the nine days since birth I had gained 45 pounds. The imprint on my chest in that photo was because I had extreme swelling…At this point I couldn't even bend my legs to fit in the car. I couldn't wear shoes. I couldn't wear my stretchy pants. I had to wear slippers that I could barely stick the toes into to walk around. I had gone from bad to really bad super fast. What made it even worse, when I saw the doctor at urgent care I was terrified, and the doctor looked at my legs and started talking, she made these comments about how nothing really looks that wrong, and

that my legs are big but aren't my legs always big? I kept thinking, this can't be real. My husband was sitting there saying, "what the hell?!" I just had to get out of that office. She gave me a prescription for a diuretic to help get rid of the excess fluid but that was really it. I still never got a diagnosis, which I think is really weird. I still don't know what caused it. I think it was either postpartum preeclampsia or postpartum cardiomyopathy. I got my discharge paperwork and it said "Reason for visit: weight gain", nothing about postpartum preeclampsia. Are you kidding me? Seriously, are you kidding me? I couldn't breathe, I was swollen to the point of not being able to function and the whole time she just thought I was fat. And to think that one doctor looked at my weight and just said, 'oh, you're a big girl', and the urgent care doctor said, 'oh, you're just there for weight gain'... I went on the diuretic, which is super intense. I brought [child] into the bathroom with me and put him in a little lounger thing because you really can't get off the toilet. You pee for 24 hours a day for like four days. They put me on a no salt diet and gave me the diuretic but no one checked on me after that. I was so upset after that visit. I never wanted to go back. It's strange to look at that situation now and realize I very easily could have died. You know what my primary care doctor said after I went in for my six week check up? He said that if I had waited another day or two I wouldn't have made it. It's strange to think that because of my weight I was not given proper care. Not just proper care of what you do as a doctor medically, but proper care from a patient perspective, from a bedside manner perspective. Just from a humanity perspective! She decided I was fat enough that I wasn't worth worrying about.

At this point in our conversation, both Melissa and I were crying. Her anguish was palpable. The injustice of the situation, and the very real closeness of a much worse outcome were harrowing. Melissa stating that the medical staff's response was strange is an understatement. It was malpractice.

From a sociological perspective, this is how oppression continues unabated. By constructing shame around fat bodies through medicalization, doctors have the authority to treat weight rather than symptoms or actual disease (Neiterman 2013). This mother could have easily died as a result of anti-fat bias, not because of a lack of medical knowledge. This demonstrates that medical discrimination (or malpractice) reaches beyond the individual fat mother and extends into the family system; thus, children become collateral damage to the ideologies that permeate the medicalization of fatness.

In September of 2022, the CDC released a report, the largest study of its kind to date, that found 84% of maternal deaths in the United States are preventable (Dembrosky 2022). This study showed that the pregnancy-related mortality rate for Black mothers is three times that of white mothers and 53% of all maternal deaths included in the study occurred between 7 days and one year after birth (Dembrosky 2022). Melissa is a white woman with a doctoral degree but even with these privileges she was still not taken care of because of anti-fat biases in medicine. Even if her weight was a contributing factor, it should not have impacted the care she received: she felt discarded by her medical team. Even though she did have contact with doctors they did not treat her with dignity, care, or respect. Melissa continued,

> I think a lot of my postpartum experience was very much related to this where the comments made before the act of delivering him melted away. After he was here I thought, now I don't have to worry about anything anymore! I had already gotten

> past the fear that I was going to have a giant baby with all these problems because I was fat, I thought we were in the clear on that. But no, the fatphobic stuff doesn't go away because then you become the fat person who's not actually having a problem, you're just fat.

Conceptualizing mothers as bodies out of control places mothers and children at risk. Focusing exclusively on the health of the fetus or baby and only the mother's weight (framed as a choice), mothers' physical health is secondary and overlooked (Waggoner 2017). As Melissa mentioned earlier, she "never wanted to go back" for healthcare. In analyzing the situation, why should she? She did not receive healthcare. She received judgment. A type of judgment that, again, made her averse to seeking further medical care. Further, her statement that she is "just fat" erases her other identities, including (but not limited to) being a mother. Going through her pregnancy, birth, and after birth trauma made Melissa realize the fatphobia she encountered had no 'end date': she would always continue to go up against it as a fat mother and fat person. In effect, perceptions of her fat body rob her of experiencing happiness that is often associated with being a new mother.

> The hospital told me to exercise more when I first called them. I was trying to get out and walk more because of the swelling before I saw the doctor, but I was really just shuffling my legs because I couldn't move. I remember thinking it was weird that they wanted me to exercise at that point. I don't know how I was up and caring for him the whole time. I just had a c-section but it was as if nothing was going on. I posted that picture on Facebook and a friend of mine made this comment about how much he loved the photo and how [child] had made an imprint on me, and I was thinking, God isn't this so sweet. I had blinders on to

> what was happening to me, I was so focused on [child]. I was going up and down the stairs, I was showering, I was cleaning, doing laundry.

According to Murray (2013), the responsibility of caring for and guaranteeing the well-being of their children is placed upon mothers. Furthermore, O'Reilly (2004) suggests that mothers are anticipated to fulfill all of their child's needs. But by fulfilling the expected care of her child and home, Melissa's own health was placed in jeopardy.

> I don't know how I was doing those things! *[pause]* I think that's what you do as a fat person in the world. You go on because that's just how it is. You don't deserve care because that's just how it is. I think that's why I wanted to do this interview so much, these sorts of stories aren't represented in the world as much as they should be. Anyone hearing this always says, 'how does this happen at all?' Yet I know I'm not the only one. This is a very, very regular, very normal thing for any fat woman. *[Melissa's child then entered the room and did a show and tell for us of his toy before Melissa continued]* He sure is good comic relief, he makes it so I don't wallow in tears for so long. It's strange now with him, I have such a different view of my body when it comes to all that. He doesn't see me as a fat mom or that my body is wrong. I'm just Mom.

Melissa's sense of self and identity have shifted since becoming a mother. She gets a lot of joy out of her relationship with her son and has enjoyed spending extended time with him at home as a result of the COVID 19 pandemic. Her quote, "that's what you do as a fat person in the world, you go on because that's just how it is," is a resignation to weight stigma. If she did not go on, she would likely be accused of being lazy, which would amplify the ideology that she, as a fat mother, does not deserve to be a mother. She would be a lazy, bad mother whose body is too out

of bounds to even be able to care for a child. Much like poor mothers who cannot financially care for their children and, therefore, "should not" have them, fat mothers are perceived as unable to physically care for their children. Having a newborn that you cannot care for would exacerbate the notion that fat women should not have children, because this is the most vulnerable time for children.

Even though Melissa initially discussed feeling worried she wouldn't be able to 'keep up' with her child once he was no longer an infant due to her size, she soon realized that though she is fat she can still be present for her child. "Keeping up", as Melissa describes in this example, mirrors Edin and Kefalas's (2005) concept of "being there" wherein the way to be a good fat mother is being able to keep up with one's child. Again, like poor mothers who rely on "being there" to resist further condemnation of their maternal role, "keeping up" allows fat mothers to resist weight stigma. Further, Melissa's child's perception of her fat body positively impacted the way she relates to her weight. Melissa said that to her child, she is just mom, not 'fat' mom. The absence of anti-fat biases from the relationship with her child improved how she felt about her body beyond that relationship suggesting an important positive shift. Her child's acceptance of her as "just mom" likely allows her to be a good mom.

Brianne, a married mother of two, also endured significant trauma during her pregnancy and birth. Her extended account is included here as it encapsulates many of the key issues around traumatic births and the lasting implications of these experiences.

> When I was pregnant with my first daughter, I went to my 20 week anatomy scan at my regular doctor. We hadn't really talked much about weight which I was so thrilled about because I was like, wow, he's not badgering me. They sent me to a perinatologist which is for high risk pregnancies and things of that nature. I didn't

know what I was doing there, there was no discussion of if something was going wrong. When I got there they said it was because of my weight, I was required to see the specialist. One of the nurses who was doing my scan said, 'you know, your baby could die because you decided to be pregnant at this weight'....and….I tried, it was on purpose! I did all the ovulation things, got tested, and everything to get pregnant with this baby. I was ecstatic to be pregnant. After she told me that my anxiety was through the roof. And for the rest of my pregnancy, it stripped me of the excitement. I was very, very anxious. And to be honest, that child is an anxious child now, because her parents experienced it after that. This is a choice that I made to get pregnant at this weight, my husband is also overweight, and then, when, you know, they look at us and say 'you need to make better choices'....Just her telling me that being categorized as obese, overweight, that I'm putting my child at risk? I had no other problems medically, nothing that should have had me at the [specialist's] office. But I had to be tested, tested, tested all the time. It really affected me and I didn't realize until I started doing birth work. I didn't post pictures or tell anybody that I was pregnant or had the baby. Like realistically this [pregnancy] could end because I chose to do things this way. That was the most negatively impactful [weight related] thing that happened to me. I had a routine pregnancy, nothing ever came up. It was never an extra this or an extra that. I looked at my chart at that place and it just said I had to go 'for obesity', I was over a certain BMI. That's the only reason I was referred to that practice. My husband took off work and went to these extra appointments with me because it was our first baby, two different places every week! All the anxiety of

> having to go there and the fear that something could happen. At the time I didn't have evidenced-based research on being obese and pregnant and how it could impact something, I was thinking if this is a medical professional, I mean, they must have seen these things before.

Not only was the nurse's comment extremely detrimental to Brianne's experience of pregnancy, neither her obstetrician nor the specialist ever sat down with her to discuss her treatment and care. Brianne pointed out that to her knowledge she did not have any medical issues during her pregnancy, which suggests that the only reason she was referred to the specialist was due to her weight–a suggestion that was corroborated by her medical chart. At the very least, the only explanation given to her was her weight, her BMI. Further, in having more required appointments, her family faced an increased financial burden when her husband needed to take off work highlighting the intersecting issue of class as well (Feldman and Wood 1997).

Brianne's anxiety was not just a personal experience but something that she believes also affected her child. This suggests that societal attitudes towards weight and pregnancy can have intergenerational effects, potentially perpetuating cycles of anxiety and stress in families affected by weight stigma. Put another way, anti-fat attitudes had a direct, negative impact on mothers' mental health (Mulherin et al. 2013). Moreover, the transfer of anxiety from Brianne to her child could potentially have long-lasting effects on the child's mental health and well-being. Her child may be more likely to experience anxiety or other mental health issues as they grow up, which could have a negative impact on their overall quality of life and future opportunities (Lawrence, Murayama, and Creswell 2019). It is possible that weight stigma has an indirect effect on children; as their mothers experience weight stigma they then may experience it or internalize anti-fat narratives through institutional interactions (e.g., school) (See Josephine's story in

Chapter Five: Feeling Fat for further analysis). Brianne's feelings of anxiety and shame also highlights the notion of personal responsibility that is often associated with fatness. Indeed, she was told by her medical caregivers "you know, your baby could die because you decided to be pregnant at this weight." This overt fat bias operates to shame and scare fat mothers.

Individual responsibility is a key component of anti-fat anticipatory regimes as fat people are framed as solely responsible for their weight and are therefore responsible for any negative outcomes that may arise due to their weight–which includes the potential death of their children. Again, comments like the one Brianne received about 'deciding' to get pregnant could be understood as an attempt to discipline fat pregnant mothers. Brianne points out that at the time she trusted her medical team to know what was best and medically necessary. This highlights the power imbalance in patient-provider relationships, where the medical professional holds a significant amount of power and influence over the patient's healthcare decisions (Ishikawa, Hashimoto, and Kiuchi, 2013). Importantly, the medical provider's power was influencing a decision that was already made. Brianne was, therefore, made to question a decision that she was intentional about making.

For her second pregnancy, three years later, she decided to go to a midwife.

> It took us two years to [get pregnant the second time]. With the midwives, we did centering, which is when you take your prenatal visits as a group. You go all in as a way to get a little bit more time to talk about issues that are going on and women who are similar to you, everyone is about on the same track. It was a different experience being with them. I ended up having a C-Section with the first child and we were going to try for a VBAC[16], which I had to get cleared by a

[16] Vaginal Birth After Cesarean

doctor. As a fat person, it was a little bit intense when we had to lay down on the bed to get our stomachs checked. I was a little bit self-conscious about my belly because it was already big. Sometimes, well, my stomach as a pregnant woman didn't look like a really round belly. It was more of a B. The people didn't make me feel like it was a problem, they pushed a little harder at times, but I felt like they tried to protect my privacy, too. I was used to [the harder pushing] from my first pregnancy. I think the issue with the centering was that I was the only Person of Color in the whole group. I wasn't having the same experiences as the other women. When I told them that I wasn't feeling my baby move, they blamed it on my weight. They said, 'oh, well, you have an interior placenta, it's in front. You're not going to feel your baby.' This is my second baby, I'm not feeling my kid move like I did before so I kept complaining about that. I came in for just a single visit by myself to get it checked out and they kept pushing it back for two weeks. Finally I went in to do an ultrasound. At that point, the baby is supposed to do a certain amount of movements in an hour. The baby wasn't doing those things. The midwife was poking, prodding, and we're shaking, anxiety was high in the room. It was just me there. They're scanning, scanning, scanning, and we could see the baby finally, the tech took a breath, but the baby wasn't doing many movements. They scanned me for an entire hour, the tech was white as a ghost. Then they went out of the room and told the midwives who rushed in and wanted to send me to labor and delivery. I asked if I had time to go home and get my stuff because I have another child! I didn't know if I was going to have the baby right then! They told me they heard a heartbeat and the baby was alive but it wasn't acting

normally. Exactly like I had already told them, even though for a long time they claimed I didn't know what I was talking about. I got to the hospital and the baby still wasn't really moving around. They monitored me. This was all right around when she was due to be born, it wasn't early on, but I really wanted to have a VBAC. I was terrified because of everything that was going on. The nurse said that I wasn't dilated and the baby was still up high and they wanted to do a repeat C-Section. I didn't know what to choose and they wanted to do the C-section within the hour so I said just do it. I had been telling them for a few weeks that she wasn't doing right and they didn't listen to me! Then, they tried to get students in the room to watch. I was not happy about that. They tried to say, 'they don't care about your body, they just want to see the baby being born'. I didn't want them in there because when you have a larger stomach they have to pull your stomach back and all this, and I hadn't shaved because I wasn't planning on giving birth. With everything going on I was stressed and I felt like my baby was in distress. The students came in. I didn't properly advocate for myself because I was just too out of it. Baby was born via c-section even though I wanted a VBAC. I really tell my people now that if you can't feel your baby move, tell your doctor immediately and show up at the hospital. They rushed and got that baby out of me but never acknowledged that it could have been a situation where there was distress. My original appointment was on a Monday but they tried to push it back to Friday. Who knows what would have happened in those extra days? After that I was done. I wanted four or five kids but that was the last one for me. I was risking my life and my baby's life because these people were not listening to me ever. 'Is

> your blood pressure high?", "Do you have gestational diabetes?" No! I don't have these things but what I do have is low fetal movement but because I'm fat you think I just can't feel my baby.

Brianne's story is quintessentially intersectional. Brianne was a victim of obstetric violence (Ross and Solinger 2017), even after putting significant effort into protecting herself during this second pregnancy and birth by choosing an alternative team of providers. Her team of midwives ignored her pleas when she knew something was wrong. Brianne felt like her complaints about not feeling her baby move were not taken seriously by the midwives. Instead, they attributed it to her weight and placenta placement–demonstrating that they, too, adhere to anti-fat ideologies, even as they claim to be more mindful. This dismissive attitude towards a pregnant person's concerns is a form of obstetric violence, as it undermines their autonomy and can put their health and the health of their baby at risk. While Brianne's medical team offered a 'choice' of whether or not to undergo the c-section, Brianne was coerced while in distress and anguished over the decision of whether or not to undergo an emergency c-section. These actions violate Brianne's bodily autonomy (Gailey 2022).

As a result of the obstetric violence she faced, Brianne decided to stop having children in order to protect her safety, despite wanting a larger family. Women's reproductive choices have historically been policed and controlled by society and the state, and particularly for Black women. It is crucial for medical staff to listen to pregnant individuals, respect their bodily autonomy, and provide care that is inclusive and respectful. Brianne's case is especially troubling, given that she sought treatment from care providers who purport to be more holistic and mother-focused. Does this mean that midwives, too, enact a type of stratified mothering that prioritizes thin mothers over fat mothers? If yes, are fat mothers safe anywhere?

Summary

While a few mothers I spoke to are social and most biological, every mother's first experiences of motherhood were shaped by their body and weight. In my initial research design I planned to focus beyond these first experiences of motherhood as most of the current research is focused in that timeframe. However, I quickly realized that these early points were absolutely central to any subsequent moments in these mothers' lives (Ballif 2022). Even when most of my interview questions were targeted at later moments, mothers' conversations frequently lingered in these moments of becoming. Some mothers were denied fertility treatment options because of their weight, which led one mother to source a prescription illegally, telling us that mothers will even risk their freedom to have access to the social role of mothering. Pregnancy, and the interactions that came from those months, had the capacity to shape both the mother's births and the years following–meaning their parenting is likely shaped by the ideological and controlling behaviors of medical staff (Ballif 2022). Further, a lack of postpartum care nearly led to the death of one mother I spoke with. This experience was overtly shaped by anti-fat bias, from both the care provider's perspective and the mother's, as she felt the need to "keep moving" to evade further shame.

At every turn these mothers faced anti-fat bias with long term consequences both emotionally and physically–and, arguably, intergenerationally. If we can argue that there are intergenerational effects to racism, classism, sexism, etc., the data from this study support the same outcomes can be associated with weight stigma. How might these generational effects shape children's lives? For now, let's take a look at how weight stigma influences fat mothers' experiences of being mothers.

CHAPTER FIVE: BEING THE FAT MOM

> *When my daughter started kindergarten, she started to realize I was fat…She started to notice I was fat in a way where she was comparing me to other mothers and she started being afraid of becoming fat herself… It was so painful for me, because I realized that even though I try to create a family conversation that is rooted in fat acceptance and body diversity as a core family value, my kids are still going to go out and be exposed to fatphobia and look at me differently.*
>
> *-Josephine, a single mother of two*

As Josephine's quote illustrates, being a fat mother means being *the* fat mom. Weight stigma permeated all aspects of life for the mothers I spoke with, even when they actively resisted it. Several mothers, like Josephine, were grappling with the reality and consequences of moving through the world as fat mothers–realizing that even their own children would be socialized to judge them. In our conversations the mothers shared their experiences of being fat mothers while breastfeeding, the visibility that comes with fatness in their communities and families, the pressure to lose weight, and existing in 'thin' spaces. I begin with breastfeeding.

Breastfeeding

Breastfeeding is a complex and often politicized issue, particularly for fat moms. Breastfeeding can be an important aspect of mothering that can impact a woman's sense of identity and bodily autonomy. However, societal expectations around weight and body size can make breastfeeding challenging or uncomfortable for some fat moms. In this section, I explore some of the unique challenges faced by fat moms when it comes to breastfeeding, as well as strategies and resources for supporting fat moms in breastfeeding.

DeVault (1994) describes the new pressure women feel to feed their families after becoming mothers. The topic of breastfeeding arose in the interviews over and over again because as Gemma, a married mother of three, said, "being the only food source for a human being is really a lot of pressure!" While women who aren't mothers may also feel pressure to feed their families, once children enter the family "the organization of the work of mothering strongly reinforces women's involvement in feeding work" (DeVault 1994: 112). Indeed, feeding is a primary way through which women are "doing gender" (DeVault 1994).

This pressure was not only from needing to feed their children in the moment but also extended into feelings about their bodies. While mothers of all sizes may feel this pressure to feed their children, the fat mothers I spoke with discussed feeling an added layer of pressure because of their fatness. The social narrative that breastfeeding causes weight loss in the person doing it and prevents fatness in the breastfed child played a part in how these mothers related to the act of breastfeeding. According to the CDC's Division of Nutrition, Physical Activity, and Obesity (DNPAO) site, the CDC "is committed to increasing breastfeeding rates throughout the United States and to promoting and supporting optimal breastfeeding practices toward the ultimate goal of improving the public's health", a clear weight-based initiative (https://www.cdc.gov/breastfeeding/index.htm). Even with the best intentions, however, some mothers cannot breastfeed.

For Gillian, a married mother of two, breastfeeding was a struggle.

> I had a lot of trouble breastfeeding so I went to formula pretty quickly. It made me mad because you always hear that if you breastfeed, the baby weight falls right off. It made me so upset that I was having so much trouble breastfeeding, that it

> didn’t work for me. I was still carrying that baby weight around! It was a parenting disappointment… if nothing else it led to body disappointment.

This quote shows a common experience among many mothers who struggle with breastfeeding and the societal pressure to lose weight quickly after giving birth. Gillian’s frustration with her inability to breastfeed and the expectation that breastfeeding would help her lose weight highlights the intersections of motherhood, body size, and self image. Her narrative reflects the cultural values and expectations that prioritize weight loss and body size over other aspects of maternal health and well-being. The mother's disappointment with her inability to breastfeed and her continued body dissatisfaction had negative consequences for her mental health and self-esteem.

The idea that her body was “wrong” if she could not successfully breastfeed was shared by Jessi, a married mother of young twins.

> I never planned on twins, so my expectations were all based off of having one child. And then I was like, if I have twins, I can just do the same thing with both kids. Right? I was like, I'm gonna be the mom that rocks them to bed every night. I'm gonna read them to sleep every night. I'm gonna do this and that every night. I was so, so, set on breastfeeding. I don't know if I just could not produce enough for them both… I just got so stressed out that I was so mad at my body because I felt like my body was failing me. I talked earlier about how strong my body is but I could not breastfeed my twins. They got nothing. I tried to pump. I couldn't pump anything. I don't know if I just didn't do it right. I got so stressed out about trying to pump for my kids that I became depressed when I couldn't produce enough milk for them.

Jessi's desire to breastfeed her children and be the "perfect" mother who does everything for her children every night reflects an idealized image of motherhood, a form of intensive mothering. While Jessi did not directly mention her weight in this story, it cannot be disentangled from her experience here. She had already accumulated a significant amount of body disappointment ("I was so mad at my body because I felt like my body was failing me") in her pregnancy and the children's first days. When faced with difficulty breastfeeding, Jessi quickly blamed her body again for "failing" her. This is not surprising considering that some mothers were told that their bodies, and specifically their fat bodies, were what caused their issues with breastfeeding. For example, Hayley's doctor's response to her struggling to breastfeed was to lose weight, further telling her that she should have lost more weight prior to getting pregnant–a fact that she cannot change now and only serves to stigmatize her. She said, "The doctors said I had too much fat tissue. I've never been able to find any research that backs that up. I was repeatedly told by several nurses that it was all my fault, to try harder and lose weight, but also eat a lot of calories for the milk at the same time". Hayley interpreted this interaction, that has stuck with her years later, to be based in anti-fat bias rather than medical truth.

Lackluster support from healthcare providers was not uncommon for the mothers I spoke with. Susan, a married mother of one, also struggled with producing enough breast milk for her child. She turned to online mothering groups for support when she could not find any in person. At first, she received even more shaming comments.

> I actually couldn't solely breastfeed my daughter. I could do it in a way that promoted our bonding but not in a way that could sustain her. I had to give her formula from about six weeks on because she wasn't growing like she was supposed to. I was really freaking out about it! I went to a couple of different

> mom groups and asked for helpful hints. Several groups said it was not a good situation. A lactation consultant associated with the midwives I birthed through told me that formula was essentially lighting a cigarette and giving it to your kid. That is not what a new mom needs to hear! Believe me, I left a negative review of that woman with her name in every online forum I could.

The lactation consultant's comment that "formula was essentially lighting a cigarette and giving it to your kid" is a harmful and inaccurate analogy. This type of shaming and guilt-inducing language can undermine the trust between healthcare providers and their patients and further exacerbate the negative experiences and feelings of mothers who are already struggling to breastfeed or are using formula feeding. Things shifted when she turned to an online mothering group for fans of the band Phish.

> Once I got my head straight, which was almost a year later, because it was truly so hard to navigate, I talked to the Phish moms about it who thought formula was no big deal! It was a weird, unexpected place to find a lot of family support. One of my friends who adopted three children with his partner pointed out that he was never able to breastfeed either. So I realized I was taking it way too seriously and I needed some perspective. But when you're in it? It's really hard. Especially when everyone is saying that breastfeeding is the best thing to do for your child. I was like, oh my god, she is four weeks old and I can't even do what's best for her?? How bad do I suck as a mom!...The Phish moms kept saying, do what you have to do, your baby is awesome, you're fucking amazing.

The intense pressure to breastfeed Susan experienced reflects the messaging agencies, like the American Academy of Pediatrics, disseminate, urging mothers to breastfeed despite a

variety of complex reasons a mother might choose to or be unable to breastfeed (Ma 2018). The medical professional Susan encountered was not helpful, and indeed used an inappropriate, shaming metaphor when discussing breastfeeding. As Ma (2018) writes, medicalization has shifted the dominant experts on breastfeeding to medical workers rather than those actually breastfeeding. This reinforces the power dynamics at play within the medical system, where medical professionals are given authority over mother's bodies and choices. When Susan turned to her online mothering community, she was validated in her experience and felt supported in a way that did not happen with her lactation consultants.

Ideas about breastfeeding have shifted over time, with mother-blame and shame ever present. Further, there exist many anti-fat paradoxes in breastfeeding education and implementation. For example, Kair and Colaizy (2016) found that fat mothers were less likely to experience "pro-breastfeeding hospital practices" than their thin counterparts. This included a statistically significant lower introduction to breastfeeding by a staff member, they were less likely to have a staff member help them practice breastfeeding, and were even less likely to be given a phone number to call for breastfeeding support after their hospital stay. While there are many factors that influence these statistics, anti-fat bias, both from fat mothers and their providers, is at least partially to blame (Kair and Colaizy 2016). This is in contrast to the popular ideology that breastfeeding is necessary to decrease the child's likelihood of obesity later in life, a facet of anti-fat anticipatory regimes.

Not only have ideologies about breastfeeding shifted, but so has frequency of use. In the United States, more than 70% of infants were breastfed in the 1930s but by the 1960s the rate had dropped to less than 30% (Hirschman and Hendershot 1979). This coincided with both the

rise in popularity of commercially available formula and an AAP[17] recommended earlier introduction of cow's milk (Fomon 2001). Again, there was a shift in infant feeding by the late 1970s into the 1990s that was fueled largely by social forces (including more women participating in the workforce), rather than medical professionals (Fomon 2001). McComas (1988) argued that the aggressive promotion of formula by the companies making it impacted the number of mothers breastfeeding. As a result of the formula industry's profit-seeking motives, initiatives like the baby-friendly hospital initiative[18] emerged. Melissa, mother of one, discussed the impact of this initiative on her birth and breastfeeding experience.

> The intention behind the baby-friendly initiative was good, the implementation is bad. There is no nursery anymore. When you have your baby, it stays in the room with you. You get skin to skin contact as soon as they're born. The mom was kind of a passive player in the past- when you had a baby the nurse would take it off to the nursery and periodically bring it back to you. Now they come into your space to take care of you. It's supposed to be promoting breastfeeding, promoting a good relationship with your baby, and having time to build that bond from the very beginning. It's really centered around promoting breastfeeding. What's happened, though, is you're forced into giving it a 'try'. Formula, in some cases, is only available if a doctor has written a prescription for it! It's not just there! When I went in to give birth I had a bit of a different experience because I had just watched my sister-in-law struggle with this. She was seriously struggling with

[17] American Academy of Pediatrics
[18] This is a global initiative launched by the WHO and UNICEF in 1991 to "protect, promote, and support breastfeeding". At the time of writing, there are 604 "Baby-Friendly" facilities in the United States, accounting for nearly 27% of all births annually. (https://www.babyfriendlyusa.org/)

> breastfeeding and it got so bad that the baby went eight hours without anything and ended up in the hospital with dehydration! The hospital was still adamant that they would not give her any formula because they said it would negatively impact her breastfeeding. She had to wait overnight for them to write a prescription when she 'proved' she couldn't do it.

While the baby-friendly initiative may be beneficial for some mothers and infants, it can also create pressure for mothers to breastfeed and may lead to negative outcomes when breastfeeding is not successful. The hospital's policy of limiting access to formulas is an example of increasing institutional control over maternal decision-making. Though she was a first time mother, Melissa went into the experience knowing exactly what kind of care she needed after watching her sister-in-law's experiences in the hospital.

> So right when I got into the hospital I spoke with the charge nurse immediately and said don't bring up breastfeeding and if you have a nurse who can't shut up about it they're not allowed on my service. I was really vocal and clear about it. If you say, oh, I'm kind of curious, I want to try it but I'm not quite sure they will run with it! They keep pushing and scare you with the things they say about the benefits and risks. Interestingly, one of the scare tactics is, if you breastfeed your baby won't be fat. They won't be fat in childhood and you're setting them up to not be fat as adults. So that's how they really get you! Because you think, oh, I don't want to purposefully make my child have a higher risk for being fat, so I must force myself to make this work at all costs. That becomes convincing yourself that whatever your body makes is enough and you won't use any other tools like a pacifier or a bottle to help you and your husband or whoever the

> non-lactating partner is. They don't need to be a part of it because it is on me to make this work. Well, of course, what do you think is going to happen? Postpartum depression and postpartum anxiety is through the roof because they can't make it work!...Don't tell her to just power through it! This stuff is everywhere. Activism is so prominent and always in these little jabs. *Don't give babies too many solid foods because then they won't get enough breast milk. If they don't get enough breast milk they're going to die of SIDS*, *they're going to be fat*, *They're going to have heart disease!*

The driving force behind this 'activism' is both anticipatory injunction and optimization (Adams et al. 2009). As stated previously, anticipatory injunction refers to the moral obligation to be constantly aware of all potential future outcomes. This functions as a requisite for good citizenship and, arguably, good mothering. The messages Melissa refers to point to a deadly, fat future based on whether or not she breastfeeds. Optimization as a function of anticipatory regimes pushes individuals to consistently update their practices and behaviors in order to achieve the best possible outcome. In this scenario, the best possible outcome (a thin child) is *only* possible through breastfeeding. Furthermore, Melissa is situated as entirely responsible for her child's future body where thinness is success and fatness is failure. This could be a driving force in why Jessi, whose struggles with breastfeeding were mentioned earlier, felt like her body was entirely responsible. Invoking the potential for future disease and death raises the present stakes extremely high even when there are no tangible crises in the present moment. The anticipation of the fat future based on how mothers feed their infants and children is creating a present crisis. It also exacerbates weight stigma, as fat women are being encouraged to ensure they raise thin children.

Melissa continued,

> Anything you can think of boils down to whether they're breastfed or formula fed, and there is always a sibling study to "prove" it. It's just not true at all. I really think this whole baby–friendly initiative is just anti-fat. That's where a lot of this stems from. It caters to thin women who want to breastfeed. If you're anything other than that, you are not going to fit into their level of care.

Indeed, a main component of the baby-friendly hospital initiative is to prevent "overweight" and "obesity" in adulthood through breastfeeding (Pérez-Escamilla, Martinez, and Segura-Pérez 2016). As Melissa points out, though the focus is on the children's size now and in the future, the anti-fat initiative is still impacting fat mothers themselves.

Willa, a married mother of two living children, echoed this sentiment. For her Toy Box item, she brought a well worn, twin-sized *My Breast Friend* nursing pillow.

> I settled on this because we spent so much time on it. A lot of our lives have been spent on this very ragged, poor little pillow. It's tied, in some way, to my size, and definitely the embodied part of parenting for me.

When her first child was born, Willa fought for a natural birth. Three days into laboring she was pushed into a c-section. Shortly after, she too faced issues with breastfeeding.

> The nursing staff were assholes to me. In my opinion, it's because of my weight. They saw a big baby, a gestational diabetes diagnosis, and a fat mother. They decided I was the reason he was like that. He had to go into the NICU after 12 hours, I honestly believe it is in part because of the care that we received. He was a big kid, there was going to be a possibility that he couldn't stabilize his sugars

> and they harassed me about breastfeeding in a way that I almost gave up on breastfeeding!

Here again the possibility of a negative outcome impacted the present, where the nurses pushed a level of preparedness that was probably unnecessary and certainly negatively impacted Willa's experience.

Rather than supporting Willa through her first experiences with breastfeeding, the hospital staff berated her.

> I was ready to breastfeed! My milk definitely came in even though they said it hadn't. My boobs were rock hard! I was leaking everywhere! You're telling me that my milk hasn't come in? That doesn't make any sense. It's hard when you're first learning how to nurse a baby and when they're learning how to nurse. The nurses would stand there and almost shout orders at me about how I was doing it wrong, to do this or that…you can't have a letdown[19] if you're that riled up. It would take me 20 minutes just to get a latch and then they would literally stand next to me with a stopwatch from the beginning of the nursing session. They would only let me nurse 20 minutes on each side, so if it took me 15 minutes to get a latch I could only nurse for five. I'd have to switch sides and start the whole thing over again. They'd supplement with formula afterwards because of concerns about his blood sugar. I was really mad at them for supplementing. Then they tried to accuse me of not caring about his blood sugar!

[19] The let-down reflex happens when a baby begins to nurse, stimulating nerves on the nipple, sending prolactin and oxytocin to the bloodstream, resulting in milk being released from the nipple. For more information, visit https://www.cdc.gov/breastfeeding/

This accusation comes from the perception that as a fat mother, Willa doesn't care about her child's health and that she is failing him. Further, forcing her to follow such a strict time limit when experiencing latching issues was not productive and led to more stress for Willa and the child.

> We were young and exhausted, we didn't say what we should have said. He was crying because I couldn't feed him, so they took his blood sugar. It came back low and they wheeled him out of the room without even letting me touch him as if it were some fucking medical emergency. I couldn't get out of bed because I had just had the c-section! I went back and pulled the records later, it was barely low, they just needed a glucose supplement. It was not an emergency and they could have let me touch him first. It was really traumatic. My husband went to the NICU to be with him and I was alone. Anyway, they kept having lactation consultants come in, and they'd give you these pillows. The damn pillows were little ones that would *not* fit! It just wasn't working. By the time I left the hospital I felt like I was leaving prison. When I got home I ordered this thing off of Amazon because after looking at the online groups, it was the only one that looked like it would be wide enough, sturdy enough, and fit. I put him on there and I did the football hold, and for the first time in the entire week long saga, he latched and it was fine. No one was yelling at me, I had the equipment I needed, nobody was standing there with a stopwatch…I'm a different person at this point in time. Now I would never stand for that kind of crap. But I was young. Even though I was 37 I was young in the sense that I was a brand new mom and I wanted to do it right.

The power wielded by medical professionals as the ultimate expert in all situations was hard for Willa to refute in her first birth experience (Hogle 2002). Willa's quote highlights the surveillance and disciplining of mothers' bodies within the medical system through the traumatic experience of learning how to breastfeed in the hospital. Willa was visibly upset as she recounted this experience to me, and the language she used to describe the experience ("I felt like I was in prison", "they wheeled him out of the room without even letting me touch him as if it were some fucking medical emergency") highlights the intensity of the situation she experienced. As Parker and Pause (2019) found, institutional fat shame results in mothers feeling at risk of complications and deficient in their mothering–something that Willia experienced immediately after giving birth. Their study found that health care providers expressed negative attitudes about their fatness through annoyance and concern, something Willa also experienced (Parker and Pause 2019).

Willa was pressured to conform to a specific standard of motherhood that was deemed 'correct' by her health care providers. As a new and young mother, she felt like she had to do everything right and follow the rules, even if they were not beneficial for her or her baby. This further highlights the power dynamics at play within the medical system and how they can affect the experiences and choices of new mothers in particular (Parker and Pause 2019). Willa then described the contrasting experience of what it was like to have her second child now that she knew what to expect and how to better advocate for herself.

> With my second it was a planned c-section, and it was easier all around and a healing experience. My new OB went out of her way to make it a healing, positive experience. We were proven parents so the staff was completely different. They left us alone. He never had to go to the NICU and I just nursed him on demand. I could trust myself to be a part of it. Once I got away from the people

> being jerks I was able to establish the relationship with my kids the way I wanted to. It's also been one of the beautiful things for me about mothering, the way my kids take comfort in my body. They do not judge any of this stuff. My kids take a lot of comfort in my physical form. I grew them, I nourished them through their first years and beyond. My body, I supported their lives. It's always a good reminder to me that despite what we get told, my body is a good body because I can do that.

Willa mentioned that as a 'proven parent' she was able to better advocate for herself and the experience she wanted to have. This is similar to Susan's directness in advocating for the kind of care she was and was not willing to receive- though Susan was a first time mother, she had the opportunity to see what her sister-in-law went through at the hospital. This suggests that experience in these spaces leads to a heightened ability to counter systemic fat blame. Willa's second birth experience highlights the importance of positive experiences and how they can impact the subsequent relationship between mothers and their children–again underlying the need to understand the experiences of motherhood as a through line of connected events.

The second half of Willa's statement provides an important recognition of transformative joy Willa has experienced since becoming a mother. For the first time in her life, Willa's body was a place of comfort and non-judgment from those most important to her. This impacted her self-image and decreased her overall internalized fatphobia. However, Willa's children are young and do not yet attend school where they will undoubtedly be exposed to anti-fat biases. Some mothers I spoke with who have school aged children noticed a negative shift in their children's relationship with their mother's fatness once they engaged with different social institutions.

Feeling Fat

I've really never been a thin person my entire life and yet being fat really felt like my darkest secret for a long time, which is hilarious because obviously it's the least hidden of any possible secret that a person can have…

-Carla, a married mother of one child

At the beginning of the first interview, I asked every mother what their relationship with their body was like. Nearly all of them shared stories from their childhood where they were ridiculed or shamed for being fat, experiences that still impact them to this day. This highlights the lifelong impact of anti-fat anticipatory regimes, the purpose of which is to slim the future through deliberate anti-fat actions. (Pearl and Puhl 2018). Brianne, a married mother of two, recalled how anti-fat messages from teachers negatively impacted her grade school experience.

> I already had large breasts in the fifth grade. We have to run, you know, and boys say crazy things. I wore two bras in middle school for physical education. It was hard for me. PE teachers felt like I wasn't pushing myself enough, especially when I got to high school. We were required to do a 12 minute mile and that just wasn't feasible for me in any way. I would put on my two bras and my PE teacher, who was overweight herself, told me in a group of girls, and I remember it to this day, she said, 'Y'all are not going to make it past 25 if y'all don't get up and start exercising'. So on my 25th birthday I thought about her and I wanted to look her up. I know her name. I wanted to say I made it to 25. I didn't die, but I feel like her saying that negatively impacted me! I had to take gym again. I failed it, but with a second coach. The way she had said that and talked to us and made us feel, we ended up just sitting down and sitting out in gym a lot. We should have

> been allowed to take longer. All of these things…I wasn't really social, I didn't go to prom. I didn't date anybody in high school because I felt like it wasn't okay for me. It wasn't acceptable to be fat. So I kind of was the funny person. My personality has always been my focus because my body type has never been ideal.

Receiving that anti-fat comment from her teacher followed Brianne into adulthood. These interactions, more than a decade old, continue to shape how Brianne moves through the world today, and built a foundation for internalizing anti-fat bias. The teacher's alarmist comment that the girls would not make it past 25 without exercise reinforces the idea that thinness and fitness are necessary for health and longevity. Brianne's comment highlights the lasting impact that anti-fat anticipatory regimes can have on individuals' self-concept and behavior.

Brianne was not alone in experiencing weight stigma early in life. Rebecca, a partnered mother of two, discusses her own negative relationship with her weight–a relationship that began at a young age when her mother enrolled her in the Weigh Down Workshop[20].

> I spent a lifetime as a child on different diets. My mom, bless her heart, was sucked into the really gross world of religion. I was in The Weigh Down workshop for a couple of years. I remember being a kid, 8 or 9, in these workshops that talked about how overeating was a sin. Oh my God it was super dark. I grew up with that kind of stuff. I know my mom was trying to give me the best life and trying to make sure I was okay and healthy, but every input she got from everyone was 'your kid is fat and that's a problem'. So it created super disordered eating and super weird thoughts about myself. That's what the church

[20] Founded in 1986, by Gwen Shamblin Lara, The Weigh Down Workshop uses faith to sell weight loss. The "Weigh Down" approach argues that God "is the missing key to rising above the magnetic pull of the refrigerator" and directs people to turn to God instead of food (www.weighdown.com).

> does anyway. I was always the biggest kid amongst my friends and I grew up as a very large person. It was a very taboo, awful, horrible thing for a long time in my life.

Rebecca's quote illustrates how diet culture and anti-fat bias can be passed down intergenerationally from a mother to her child. As a result, Rebecca experienced disordered eating and negative body image from a young age. While her mother negatively impacted her relationship with food and her body, Rebecca discussed the many ways she is intentional in breaking that pattern with her own children.

> I am very cognizant of not passing that [disordered eating] on to my kids. My kids are both normal size at the moment, they're two and five with very healthy eating habits. I put out food and they get to pick from that. Sometimes they choose dessert first and sometimes they choose cucumbers. It's a very open ended thing. I try not to put any weird guilt or pressure on that because I know how shitty it was when I grew up!

Rebecca recognizes the harm of exposing her children to diet culture like she was growing up. Even as a child, Rebecca knew, through comments like "your kid is fat and that's a problem" that her fat body was wrong and her mother was trying to 'fix' her. Fat children are socially depicted as a result of poor parenting, leading to mothers being stigmatized and fat children being subjected to public shame and humiliation (Ioannoni 2017; Davidson and Lewin 2018). Mothers are framed as accountable for the weight of both themselves and their children (Ioannoni 2017). However, in her own role as a mother, Rebecca is being intentional to protect her children from the same experiences she had growing up. In this way, she is 'being there' for her children while directly challenging anti-fat anticipatory regimes.

Sara, a married mother of two, also struggled with body disappointment for most of her life- until she became a mother.

> I was terrified, deeply, that someone would look at me and think I was fat. It was the scariest thing in the world to me and it kept me from living the life I wanted to live. Motherhood changed the way I look at my body and it began when I was pregnant, I loved the way I looked pregnant! I had a new appreciation for my body and what it could do.

The process of pregnancy and childbirth led Sara to a shift in her self-image. Where she initially talks about her body as something people looked at, her body is now a place of strength and capability. For Sara, being pregnant was the first time her body was accepted and her fatness was not breaking social boundaries in the same way as pregnancy is an acceptable, temporary kind of fatness (Nash 2012). That period of being pregnant opened the door for feeling good about her body in a way that she had never experienced before, and thankfully carried over after giving birth. This suggests that a reduction in social anti-fat bias could increase overall wellbeing and self-esteem for fat mothers. Sara notes:

> In the last few years, I'm sure you can probably tell by some of my appearance and our conversation that I am pretty gender queer. I do still identify as a mom and I use she/they pronouns but I definitely don't feel the level of obligation to perform femininity that I used to. I think the combination of being a person in my mid 30s, having two kids, being in a stable partnership, there is an element of…I don't feel like I'm presenting myself as sexually available. I'm not dating, I'm not in that stage of life anymore. So I get more of a pass. It almost protects me from

> people's judgment a little bit!...I do really identify as *Mom* too, being *Mom* feels genuine and a deep part of who I am.

I asked Sara if her body and weight ever impacted how she related to her gender.

> I was so scared someone would see, you know, see me, see what I look like. I didn't want people to know I was fat. I wore dresses that give the slimming illusion, they kinda come in at the waist…For me, body acceptance and gender acceptance went together. I can't even tell you how much freedom I have started to feel!

Previously, Sara felt the need to make herself smaller and more 'palatable' by thin, heteronormative standards of beauty. When they began on a path towards 'body acceptance' and 'gender acceptance', however, the pressure and shame receded. The process allowed her to accept both her body and gender. The intersection of being queer and fat was important for Gemma, a married mother of three, too.

> I think my experience of being a fat mom is different because I'm also queer. I mean you're already out here being weird. You might as well also be into fat positivity and be more weird. The pressure to perform traditional femininity and hate yourself is like way less. Most of the fat moms I know that are straight, they don't identify as fat. They don't want to talk about it. They wish they were different. A lot of them have had surgery in the last few years. Several of them now regret it. And that makes me happy.

Gemma's quote illustrates the ways in which her experience as a fat mother cannot be separated from her queerness. Fat liberation has long been intertwined with queer liberation (Tonic 2022). Indeed, Gemma felt that being queer had already placed her outside of an

acceptable femininity and the barrier for entry to fat positivity was significantly lowered. Gemma had already experienced marginalization which made it easier for her to reject and resist the dominant standards that stigmatize fatness. Anti-fatness influences the expectations surrounding how femaleness (and motherhood) should be expressed and embodied, including the specific type of body that is deemed acceptable (Davidson and Lewin 2018). Through this intersecting embodiment, Gemma felt more empowered to challenge societal standards and expectations around body size and gender expression. This was in contrast to other fat, straight mothers Gemma knows who hesitate to accept their fat bodies, sometimes going as far as undergoing surgical intervention. Interestingly, several straight mothers I spoke with also felt pressure to undergo either surgical or medical weight loss efforts, as will be discussed later in this chapter. Fat bodies subvert normative body ideals and as such fat *is* queer (Hartley 2001; Mulder 2021).

The intersection of gender, queerness, and weight came up in my conversations with Josephine as well. Josephine, a single mother of two children, has attempted to raise her children with body neutrality. However, at 8 years old, Josephine's daughter has been displaying fatphobic behaviors. This has been incredibly hard on Josephine who describes herself as a large fat woman. One of the items Josephine brought to our second interview was a nude Barbie doll. She explained her daughter has nearly a hundred spread throughout the house. When I asked whether or not it was unusual for the doll to be nude, Josephine said that the first thing her daughter does when a new doll comes into the house is to strip all its clothes off. She laughed and said the doll she picked was not one of the ones she most despises, which have more "pornographic", exaggerated bodies, but was closest to her. For Josephine, the dolls themselves were interchangeable as they all represented the same problem: a growing hatred of fat bodies in her daughter.

> She's already fatphobic. She's talking about how she doesn't want to be fat like me and is already pointing out how I am different from the mothers of her friends. She says it in a way where she's almost trying to console me…she is apologizing for acknowledging that I'm "bad". She talks about the fact that she is non binary but I don't know what to make of it. Part of me thinks that she sees her brother getting an extra bit of attention for being trans and wants a piece of it. Part of me thinks it's because she really idealizes a boyish, androgynous figure because she just doesn't want to be fat. She sees me as a womanly, maternal figure. We talked about her getting breasts and she is terrified because she sees breasts as fatness. I think that sometimes when she talks about being non binary it's actually a form of fatphobia.

Josephine's body has become the template for what not to become for her daughter. Hill, Weaver, and Blundell (1990) write that parental attitudes on weight are both taught to and accepted by their children from a very young age. However their study, and others like it (Yamazaki and Omori 2016; Brown and Ogden 2004), focus on attitudes that favor thinness, rather than weight neutral or fat positive attitudes. While there are no studies (to my knowledge) that look at the relationship between fat positive parental attitudes and their impact on children's weight-based attitudes, Josephine's story suggests that while she has worked to instill a weight neutral attitude in her children from birth, it has not overridden external anti-fat influences. In fact, as Josephine said, her daughter is outwardly displaying anti-fat bias. It is not uncommon for children to develop biases and stereotypes based on the messages they receive from their surroundings (King 2021). If almost all of the messages Josephine's daughter is receiving reinstill anti-fat ideology, her mother may represent what she is taught is wrong by outside

forces. Josephine's body is a constant reminder of her child's anticipated future–which demonstrates that not only are fat mothers influenced by these anticipatory regimes, but they also operate and order their children's lives. Understanding that her daughter is not only fearful of becoming fat, but also questioning her gender because she views female body parts (e.g., breasts) as fat demonstrates the magnitude of power anti-fat biases wield.

In fact, Tonic (2018) outlines how fatness impacts androgyny and, in particular, how thinness is more often read as nonbinary. In this case, Josephine's daughter may be equating thinness with being nonbinary, believing that to be nonbinary means to reject traditional binary gender norms, including those associated with body size and shape. It may also mean that she assumes if she does not become a woman, she will not be fat–which not only serves to reject her gender, but her mother as well. Josephine repeated that she did not have an issue with either of her children's gender journey and supported them both. Josephine also knows her daughter is looking to other mothers' bodies to hold hers against what 'should' be. Her daughter's anti-fat behavior has been really difficult to navigate for Josephine, and it has taken a toll on their mother-child relationship. I asked if her son displayed any of these same feelings to which she said no. Her son may not be displaying the same types of feelings as he does not see his "embodied" future in the same way–meaning he may not be witnessing what he thinks he will become.

Fat in public

Several mothers described a feeling of constantly being judged in public for a variety of things related to their bodies, even if the voice was internalized judgment. This internalized disciplinary voice is what Murray (2013) describes as the "panopti-mom: an echo chamber in

which mothers are constantly subject to the gaze and judgment of other mothers" (176). While the panopti-mom phenomenon is not unique to fat mothers, the experiences shared with me show that this feeling of judgment is layered and intertwining.

We can see the panopti-mom play out in spaces where mothers interact with other mothers. Most of the mothers I spoke with sought out community with other mothers at one point or another to share the journey of motherhood. Some were more successful in online communities, especially after the COVID-19 pandemic began. While communities of mothers have always existed in some shape or form, the rise of internet groups, specifically on sites like Facebook.com, has seen yet another wave of rules of good mothering (Clements and Nixon, 2022). Plus-size specific communities online (like Facebook groups) can sometimes be really fat-positive, supportive places, though this is not always the case. Nena, a married mother of one, joined a plus size pregnancy group when embarking on her TTC (trying to conceive) journey where she was encouraged to find an OB who would not focus on her weight. Others, like Brianne, a married mother of two, attempted to find in-person community with other mothers that was not specifically for fat mothers. Her midwife's group functioned as a cohort during pregnancy and after the birth. Brianne discussed the ways in which she felt alone in this group.

> I was the only one who was Black and the only one who was overweight or obese, everybody else was really, really skinny. Sometimes when I would talk about stuff that happened to me they'd say things like, 'culturally maybe your blood pressure is higher because in People of Color diets can contribute to that'...it wasn't asking what I was personally eating, it was broad statements about Black people in general.

The fact that the mothers focused on the "cultural" aspects of Brianne's life demonstrates how Brianne's experience in the group was impacted by the "gaze." The mothers comments indicate that Brianne is hypervisible as a Black mother as they conflate her weight with her race and, consequently, her health. Brianne went on to say:

> We also had different political beliefs and it was election time. I know people might think it's a stretch but I feel like the race part of it, and also the way the world sees them and how they move through the world would lead them to choose differently than I chose [politically]. I'm not a religious person but if there was a prayer I would participate to help with their comfortability, but I felt like they ran the show and I was just kind of there. We went to their houses after the kids were born and did a few group things. They lived out in the suburbs and I lived in midtown so we focused more on going out that way so it would be more comfortable for them… Assimilation didn't make a difference because at the end of the day, I was fat and I was Black. They had snacks and stuff that they brought, right? To provide us with something to eat, but none of that stuff were things I really ate. 'We got bell peppers, that's good for you, you can munch on those!'. I don't munch on bell peppers. But I didn't want to bring the things…like, who is going to roll in there with a McDonald's sandwich while everyone else has a yogurt? They'd just say it was because I was fat, that's what they would expect me to eat. I usually didn't eat, or I ate a little yogurt or some crackers, but not too much with them. For other moms they'd tell them to eat, they needed to eat more…but they didn't say that to me.

Brianne's acknowledgment that she was not "going to roll in there with a McDonald's sandwich while everyone else has a yogurt" is evidence that she felt oppressed by the gaze. "Munching on peppers" is a capitulation to weight stigma, an outcome of internalized fatphobia. While many of the mothers may be conscious of what they eat (which due to data limitations we cannot ascertain), it is clear that Brianne's participation in the community was regulated by her negotiation on what she *should* and *should not* eat–surrending her desired food for food that will lessen the impact of the gaze and, perhaps, other mothers' judgment. Though they had gone through this shared journey of pregnancy and childbirth together, their experiences were vastly different. Brianne faced intersecting racism and anti-fatness both in her medical care (discussed in chapter 4) and also her mothering community.

> I didn't understand until I was a mother that there was kind of a game you had to play to get into certain mom groups, politics around who's going to be accepted here or there. Race, weight, class, all come into it. If you don't have the money or you don't live in this certain area, forget it. When my child was young I ended up becoming friends with this one mom who had a similar experience to me. She was white, she was just slightly overweight, she didn't have a lot of money, so she and I kind of had some of the same experiences and our kids were the same age. But the politics of it is really, really difficult to maneuver. I've known a lot of mothers who think you have to be Black to have the same experience. Medically, I can see that. I can see myself being similar in those ways, but I also think that my weight added on another form of oppression.

Race and weight played a central role in how Brianne navigated being in community with other mothers. Other factors, like class and political ideology, also impacted her ability to find positive

communities–and influenced who she felt close with. Brianne faced significant pressure to assimilate into a very white space. These negative experiences were so impactful for Brianne that she moved her family to be closer to extended family.

> I always wanted to be a mother from the time I was a child. I wanted to do everything for my children, be president of the PTO and all. Once I was hit with the weight thing when I was pregnant with my first child…the anxiety from that, and then parenting from an anxious place…it changed my parenting style. I said, well, I've already messed this up for me, let me try to make sure that my child has the best possible outcome from the situation. I took less risks, I put myself out there less after being shut out of certain things. I really struggled to find a group of people that I felt like were acceptable, that I was acceptable to be with.

The fact that Brianne moved her family and changed her parenting style indicates that the panopti-mom, like the panopticon, worked. The surveillance Brianne felt she was under controlled her behavior. She not only moved to be closer to extended family (which, arguably, meant she was moved closer to those who could guarantee a known support) she isolated herself as a parent. Her quotes that she "took less risks" and "put [her]self out there less" meant that she perceived her body was operating out of bounds in a space that was meant for thin mothers. She perceived her body was being read as wrong.

At the end of our second interview as we were wrapping up, Brianne talked about how our conversations shifted the way she viewed herself and her previous experiences. "I know that I'm fat, but I never even thought about it this way. Being Black and fat are now neck and neck for me." Brianne's experience highlights that multiple forms of oppression can lead mothers to conclude that they are not welcome, they cannot parent in the ways they have always dreamed

about, and that they should just go away. Brianne's experience highlights the fact that "motherhood is not a private enterprise. It is endlessly and exhaustively public" (Donath 2017: 31). This is further demonstrated by Jessi, a mother of two, who explained,

> Now that I am a mother, I feel like people might look at me and then judge me against my tiny kids… I feel like as a plus size mom, people might be questioning why I'm not feeding them even though I look like I eat a lot. These are words and voices I hear in my head, I know, I don't know if people actually say this about me but I do think about it a lot. I feel like I have to defend myself sometimes and be vocal about how I really do feed them but sometimes they don't want to eat and I don't really know why they're not gaining weight. I don't want to be looked at as the plus size mom that has skinny kids.

Overall, there was often tension with the size of their children, regardless of whether the children were fat or thin. There are a handful of studies investigating the relationships between children and mother's respective size (Yamazaki and Omori 2016; Gorlick et al. 2021; Davis et al. 2018) though these investigate the relationship between mothers with fat children, and not fat mothers with thin children. These studies do, however, discuss the ways in which mothers are framed as responsible for their children's weight (Gorlick et al. 2021). Jessi's twin children are still very young, and as the children grow older will be seen as more responsible for their own bodies and weight. However, this is still a very real stressor for Jessi as she mothers day-to-day where she finds herself justifying the twins' weight to those around her, responding to the panopti-mom (Murray 2013).

Nena, mother of one, described this daily self-policing she experiences.

> I have to be fully dressed with a bra and everything to take him to school, even when I'm sick. Because I worry that if I was to look sloppy, it would be used as a judgment against me. Instead of them seeing a thin mom and saying 'oh, she looks tired' or 'she has been sick', it's 'oh, she's fat and sloppy'.

As discussed in Chapter 2, fatness blurs normative femininity (Bell and McNaughton 2007), and as weight increases so must the performance of gender. Davidson and Lewin (2018) state that anti-fatness impacts the standards of how femininity (and motherhood) should be performed, and those who have bodies outside these norms may face harsher punishment (Butler, 1988; Versluis, Agostino, and Cassidy 2020). This pressure was felt deeply by Nena who has subsequently spent a substantial amount of time on her appearance (even when ill) when walking through the world in order to reduce judgment from others (Versluis et al. 2020). The way Nena looks, she felt, determines *who* she is and *how* she is perceived as a mother because of anti-fat biases and panopti-moms.

Equally important is the fact that even when nothing is explicitly said about their weight and bodies, the mothers experience anti-fatness all around them as they operate in a world built for thin people. Kate's experience with the examination table (discussed in the previous chapter) illustrates this. We can also see this when Jessi discusses her desire to buy certain items. Jessi wanted to buy a trampoline for her children but has yet to do so because they come with a low weight limit that would prohibit her from joining them in the activity.

> I want to be able to do those things with my kids. Even when things don't have that weight limit I feel like I'll be looked at funny for playing with them. We're going to a birthday party tomorrow at a trampoline park. We're going to be in public. I don't know if I'm gonna play with them because we'll be in public. I

> don't want people looking at me…Last year I was at our waterpark and someone in front of me took a picture of me. I saw them send it on Snapchat and talk about me on their phone. I didn't know who this person was…I didn't say anything to them because I am shy and don't talk to people…Last summer I finally had the courage to wear a bikini out in public. I even bought a second bikini and wore that one out as well….until the person took my picture. It's kept me from going with my kids to the water park since. There are a few things I've stopped myself from doing because of my weight and the way I look. I won't ever forget how I felt that day.

Jessi's quote highlights that mothers feel direct effects of the panopticon. There was no question that she was under surveillance. Ubiquitous phone cameras have become modern-day panopticons that discipline fat mothers' bodies—which allows for the women's bodies to not only become hyper-visible within that space, but disseminated instantly throughout social networks. Importantly, this instant transmission allows for broader discrimination against fat bodies, as these images spread quickly. Further, the anonymity of both Jessi and the purveyors may increase viewers' freedom to judge, shame, and laugh at this fat body. The dissemination of images of fat mothers increases fatphobia through derision and, consequently, leads fat mothers to discipline their bodies—and their children—through self-exclusion. The mothers' responses to the "near-constant surveillance" of their bodies is to not interact in spaces where they are visible (Murray 2013: 166). As a result, then, mothers do the work of reproducing their own social inequality, as they self-discipline through exclusion; thus, their macro-level attitudes in regards to fatness and micro-level actions (e.g., onlookers taking pictures of their bodies) ultimately

mean that mothers themselves will assume the responsibility of disciplining their own bodies and regulating their social interactions—much like the Panopticon (Murray 2013).

Some mothers had experiences where people were outright anti-fat towards them. Soon after Allana's child was born, she began working as a substitute teacher at the local high school.

> I was substituting for an English teacher. I knew the teacher, he was a super tall, super skinny guy…One of his students said it looked like I ate the teacher. I didn't say anything because what do you say? But it made me feel like shit. I had just had a baby not long ago. It was horrible.

Allana explained that it was draining and nerve wracking to constantly be anticipating anti-fat comments as she moved through her life. In a more direct and intentional way as compared to Jessi's four year old students, Allana's high school students were unapologetic about their anti-fat bias despite Allana being in a position of power.

It is one thing to anticipate anti-fat comments from those you don't know, but for Josephine, a single mother of two, dealing with her daughter's anti-fat attitudes has been heartbreaking.

> When my daughter started kindergarten, she started to realize I was fat. I made it really clear in our family conversations that fat is not a bad word and it is not an insult to say someone is fat. She started to notice I was fat in a way where she was comparing me to other mothers and she started being afraid of becoming fat herself. She was picking up fatphobia from school and applying it to us. It was so painful for me, because I realized that even though I try to create a family conversation that is rooted in fat acceptance and body diversity as a core family

> value, my kids are still going to go out and be exposed to fatphobia and look at me differently.

Josephine's daughter became the panopticon. This almost functioned as role reversal, where her daughter is disciplining her mother or becomes the panopticon her mother needs to defer to. Whereas Murray (2013) argues that "panopti-moms" exist to surveil mothers, Josephine's parenting experience demonstrates that this surveillance is inside her household—thus, subjecting her to an intense, incessant gaze from her own daughter. While Jessi can avoid water parks and the people who patronize such places, Josephine cannot escape her daughter's gaze. Josephine's experience, then, is very similar to Bentham's conception of the panopticon.

Anticipating a lack of suitable options for her fat body, Susan preemptively bought a larger size gown to deliver at the hospital. She brought the gown as her second contribution to the Toy Box.

> The logistics of things like hospital gowns and robes…the reason I always travel to get my mammograms every year is because they have goddess size gowns to wear. I don't have to do the walk of shame with two attached robes. I was really concerned about that going into my delivery. There are so many things to be concerned with when you have a high risk pregnancy and I knew I wouldn't be able to do a lot of the crunchy, natural things I wanted in birth. I was going to be in the hospital for a long time and one thing I knew I did not want was being stuck in two hospital gowns tied together to fit around me. Of course there is the option to just go naked but I was not ready for that. I was going through labor for 20 whatever hours and I was not about to be just naked while people were wandering in and out and I was listening to fucking Enya or whatever. So I looked it up and

> got this sleeveless dress that buttons down the whole front and back. That way when you have to expose your stomach to get all the monitors on or if you have an epidural and you need access to the back, you're good. It's also a breastfeeding dress. This thing made me feel more normal than a lot of the things that I tried in order to feel normal during my pregnancy! Especially during my birth, I mean I wore this thing like a maternity dress because in the last six weeks of my pregnancy I had to go in every week for extra monitoring. It was so nice to just be able to unbutton a little bit here and there and not have to worry again that they might not have robes to fit me. In the academic sense I know it's silly, these people see all kinds of bodies. But I also know from personal experience and from the experiences of my fat friends who have been pregnant, going to an ultrasound and having an ultrasound tech tell them *I can't see anything through your fat* and stuff like that…I was already so worried about this I didn't want to add worrying about the sizes of the fucking robes to the mix… I haven't gotten rid of it and my kid is five and a half years old. I haven't put her to my breast in a very long time, I'm certainly not planning on being pregnant or giving birth again. I just can't get rid of this thing. It's like a talisman. It helps me feel a little bit more normal, a little bit more, you know, whatever. Ultimately, my kid would have come how she did if I was naked giving birth or if I was in three hospital robes tied together. But this gave me comfort in my body.

Susan's delivery gown was a way to advocate for her needs while protecting herself. Furthermore, the use of the term "talisman" to describe Susan's gown suggests that it held significant symbolic value for her beyond just its practical use. A talisman is typically an object

believed to have magical or protective powers, and in this case, Susan's gown served as a source of comfort and protection for her during a vulnerable moment. This speaks to the emotional labor that fat people may have to engage in when navigating medical settings, and the importance of feeling seen and valued in those spaces.

It is important to have hospital gowns available that fit a variety of patients because it is necessary for patients to feel comfortable and dignified during their medical treatment. Wearing a gown that doesn't fit can make patients feel exposed and vulnerable, which can negatively impact their mental and emotional well-being as Susan described–it can also lead to more derision, as it is clear that fat bodies are operating out of bounds in these spaces. Additionally, ill-fitting gowns can make it difficult for healthcare professionals to perform necessary medical procedures and exams, which can lead to delayed or inadequate treatment. Having gowns that fit a range of body sizes can help ensure that all patients receive the same level of care and are treated with dignity and respect. The fact that Susan has held onto the garment for so long is significant because it speaks to the emotional attachment and value of her gown.

In a similar vein was Brianne's Toy Box contribution: her minivan.

> When you have a new baby you also have a pretty bulky carrier that you have to get in and out of the car. So this one time I parked my Nissan Altima and no one was there in the parking lot. When I got back I literally could not get myself or that carrier into the car! I was panicking like, what do I do? That's when the minivan idea came in. My daughter wasn't even a year old before we got it because the doors slid. I could easily walk all the way to the back of the van and I didn't have to feel ashamed for someone to see me trying to squeeze in from the passenger seat or anything like that. Even breastfeeding was easier because I had

> the space to do so in the car. People really thought that was weird. I only had one kid at the time so why did I need a van? I always just said things like oh, well, I can put the wagon in the back and it's a lot more space. But really, it was more space for my husband and I because we were both bigger! I could turn around and get things to my child, it accommodated me a lot better. I didn't feel comfortable in other vehicles. When I go to other places with somebody else in a car I always worry about where they're going to park and ask them to park at the end. That way I won't have to be stuck in a situation where I have to contort my body to get in the car and be embarrassed. The minivan really took away a lot of my parenting anxiety! I was young having a baby and vans aren't cool. A lot of moms don't want the van and they only get it after having too many kids for a car. It wasn't normal to jump right into a van. But those people weren't bigger people who were making those comments. It really worked for us but no one really understood. And, I never really explained it either. I realized that I could control this aspect of my life and go to the grocery store without having to worry about getting in and out of the car. You're going out in public, still bleeding, barely able to walk around, like going and parking far away is more difficult. Spaces are tight and people don't care how they parked next to someone else's car.

Brianne's story illuminates several points. First, it sheds light on the ways in which societal norms and expectations can shape personal choices, particularly in relation to fatness and motherhood. This quote also speaks to the challenges of navigating public spaces as a new parent in the US, particularly with regards to parking, access to privacy, and community. Brianne describes feeling embarrassed and uncomfortable when attempting to get in and out of a car in a

public space, and how the minivan provided an immediate solution to these issues. In the process of prioritizing her individual and familial needs, Brianne stopped conforming to social pressure and standards placed on her by family and friends.

Weight Loss

Health is a complex, variable state impacted by numerous factors. Stories of interactions with doctors and other health care providers continued to permeate mothers' reflections. One story was particularly salient. Susan had weight loss surgery a few years after her child was born, though she was pressured to have it during the time she was trying to conceive.

> I got it for health reasons… I didn't go into it so I could wear a cute dress at a high school reunion or so I could wear a bikini in front of my ex-boyfriend or whatever. I'm not judging people who do have these things as their reasons but it really wasn't mine. I have nerve damage in my feet that hurts me every second of every single day. A few doctors told me that this might be something that could help it. I also have high blood pressure, sleep apnea[21], and PCOS. So I don't always get periods, and I have some issues connected to that too. Doctors have all suggested weight loss surgery to me, of course, because you know they love to talk about surgery of any kind.

While WLS is touted as an almost panacea (Groven et al 2018), especially for women, studies suggest that within a year after surgery patients have regained weight (with specific percentages depending upon several factors including type of surgery and patient populations) and report decreased quality of life and psychological well being (Galli et al. 2018). Weight loss

[21] Sleep apnea is a common sleep disorder characterized by repetitive starts and stops in breathing.

surgery is also framed as ‘stomach amputation’ to some fat activists and scholars as this voluntary surgery intentionally impacts a healthy organ (Richardson, 2004). While Susan initially decided against undergoing weight loss surgery when trying to conceive, she ended up undergoing the surgery when she felt her weight was impacting both her physical health and ability to mother.

Susan was not alone in feeling that her body and weight were impacting her ability to be fully present in her daughter’s life. When deciding whether or not to undergo this surgery, one of her doctors urged her to reconsider.

> Initially I really appreciated what she was doing, because she asked me to journal all of the reasons why I wanted to do [the surgery] no matter how silly I thought they were. I ended up with like 25 reasons. And one of them was something like, wouldn’t it be really nice to just shop in a regular store…And as she is reading through these reasons she was just like, ‘these problems are just patriarchy bullshit, it always goes back to vanity’. No, no no no. I don’t care about the vanity side of things. I’m letting my hair go gray, I don’t wear makeup, I barely wear a bra. But I was so kind of….ugh. She also made me journal about what the worst case scenarios could be. Like what if I got all the worst side effects, what would I do if I became so vitamin deficient that I had to go on an IV once a week. I appreciate all of that because I’m sure a lot of people go into this surgery thinking it’s just going to be fantastic and I can’t wait to wear a bikini or whatever… I’ve talked to her a few times since then with small things and she was really dismissive and almost aggressive. I asked her what was going on, and literally asked if I said something that had offended her or something. She said, ‘yea, I just

can’t believe you went through with that surgery. You’re trying to deny who you are’.

Susan repeatedly insisted her desire to undergo WLS was purely for health reasons, but she also brought up several social and emotional reasons. These reasons reflect a society that is anti-fat and highlight the reality of living as a fat person in it. For some fat people, becoming thin is a way to become socially acceptable and less likely to face discrimination. These reasons are also what make the first year after surgery so impactful for those who undergo it. Though Susan’s doctor rejected anti-obesity medicine, she was still not supportive or respectful of the kinds of medical care Susan wanted. Despite the doctor's fat-positive approach, she may not have fully understood or addressed Susan's needs as a patient. It is not unusual for fat people to want to lose weight- quite the opposite. As Susan mentioned, one leading reason for her desire to lose weight was to be present and participatory in her child’s life. She could not envision ‘being there’ for her child as a fat mother. It was worth risking all of the potential negative side effects of surgery in order to no longer be fat for her child. The doctor's dismissive attitude towards these reasons made Susan feel unsupported and unheard.

The idea that you ‘are’ your weight, as Susan’s doctor suggested, seemed to be confirmed by others I spoke with. Carla, a married mother of one, said, “I've really never been a thin person my entire life and yet being fat really felt like my darkest secret for a long time, which is hilarious because obviously it's the least hidden of any possible secret that a person can have.” For Carla, identifying as a fat person meant she finally would be fat. Saguy and Ward (2011) wrote about the process of “coming out as fat” and how it has the potential to assert fatness as neutral or positive (1). When one claims or even just accepts their fatness, they are no longer a

thin person trying to get out (Saguy and Ward 2011). Laura, a married mother of two, also described what it was like to accept her fatness.

> I thought I couldn't wear food clothes, I couldn't wear a shirt in public that said 'I love pizza'! But then I realized, why not? Who cares? It's funny because I didn't realize I still had this problem and my wife and I actually got into a little fight about it. She wanted the shirt and I said I couldn't wear it even though I loved it. She asked 'why not? It's not like you're fooling anybody just because you don't wear a shirt that says 'I love pizza' on it.'

When confronted with the fact that she was struggling with internalized fatphobia from her wife, Laura was able to process her feelings and ultimately, Laura was able to embrace her body and wear the shirt she loved. From then on, the t-shirt was a public confirmation that Laura was comfortable in her fatness.

Several of the mothers feared a fat future for themselves and sometimes for their children. Many were currently undergoing weight loss efforts ranging from dieting to medication to considering weight loss surgery. When talking about fearing the fat future, the narrative was frequently the fear of not being around for their children down the road. Sometimes being around meant literal life and death, while other times it meant being around in a way that is only appropriate for thin people. Gillian, a married mother of two, spoke about her feelings on the future, and this particular conversation happened during our second interview:

> I hate to say this, it's just strange. I hope that in my future I'm not a plus size mom. I want to be an average size person where that nagging isn't always there. Or like, what if my child gets into running when she's 12 and wants me to run with her? I want to be more participative in any way that they feel like they want

> me to be as they grow older. If I am a plus size mom in the future it wouldn't be the worst thing in the world. People do it every day and they're fine, they're doing their thing momming real hard…but I do feel like in the future for me to be a happier mom I need to lose weight. The happier your mom is the happier your kids are, in my opinion…I'm on pills, my doctor prescribed me Adipex-P[22] and I just started it yesterday. It's phentermine, one part of the bad fen-phen but not the bad fen. I guess it's like an appetite suppressant slash stimulant, it's supposed to give me more energy and stuff. Now I'm at this weird intersection of, 'no I won't have surgery but I'll take a pill'. I was very adamant about not taking pills for the longest time but now I guess I'm at that point where my children are six and four and I'm getting older, this weight isn't going to fall off overnight. That's why my doctor suggested them…I finally caved and decided that since I'm not taking care of myself, this prescription will be the kick in the pants I need it to be… I see a future of me striving to not have to worry about the things I worry about as much. Maybe I'll win the lottery and get a tummy tuck. You never know.

For Gillian being a fat mom means being excluded from an active role in her children's future. She also discussed that as her children have moved from toddlerhood to preschool and school age, her fatness can no longer be attributed to pregnancy weight gain. Further, while Gillian was unhappy with her weight she was not seeking medical intervention for weight loss assistance. While the doctor acknowledged her busy life, Gillian used the word 'caved' to describe her 'decision' to begin taking weight loss pills. In this context, the word 'caved' refers to Gillian's capitulation to societal pressure to conform to a certain body size and shape. Despite her

[22] This is a brand of the drug phentermine, which is used for weight loss.

initial reluctance to take weight loss pills, she ultimately gave in to the pressure to lose weight and took the medication. This highlights the ways in which individuals can feel trapped in a system that prioritizes thinness and stigmatizes larger bodies. Gillian's desire to be an active participant in her children's lives and her fear of being excluded due to her size demonstrates the ways in which weight stigma can lead to feelings of shame and exclusion. The way both Gillian and her doctor discussed 'taking care of herself' was relegated to weight alone, further perpetuating the idea that weight loss is the only path to health and happiness.

Some mothers, on the other hand, didn't feel that pressure from their doctors- at least in the sense that immediate weight loss was necessary. Jessi, a young first time mom of twins, discussed the pressure she felt from herself to lose weight during pregnancy.

> When I actually went to the doctor, she said nothing about my weight…And one of the first things I told her, I was 20 years old, I said, 'I know I'm obese.' but she said, 'No, don't worry about that, your weight is your weight right now. I don't want you to starve yourself because you wouldn't lose weight. You're pregnant now. Maybe eat healthier, but don't worry about a specific diet. Just focus on having a healthy pregnancy.' Part of me felt like I couldn't have a healthy pregnancy if I wasn't skinnier.

While her doctor did not pressure her to lose weight immediately, the suggestions given (i.e. eat a healthier diet) still reflect an anti-obesity model and include assumptions about her based on her weight (like that her diet isn't already healthy). Furthermore, the internalized pressure and anticipation Jessi felt could be seen as a direct result of anti-obesity rhetoric and narratives of health and pregnancy. Jessi spent her pregnancy waiting for her doctor to shame her about her weight and continued to anticipate this after her twins were born. Even in more mild cases of

weight-related care, there is still intense pressure for fat mothers to lose and/or maintain weight during pregnancy (Davidson and Lewin 2018), even if this is internalized pressure that comes from years of messages about who they "should be" versus who they are..

Fitness and exercise

Navigating fitness and exercise came with feelings of shame, guilt, anxiety, and apathy for the mothers I spoke to. In discussing fitness and exercise, most mothers (and those they interacted with) directly tied these activities to their fat bodies, their futures, and their worthiness. Sara, now a fitness professional, struggled in these spaces for a long time because it felt like they were really just weight loss programs. She said, "Every time I'd go to the gym, the personal trainers would ask me, 'what's your goal weight and how can we get you smaller? How can there be less of you?'". Gillian, a married mother of two, discussed feeling ashamed of the fact that she no longer exercises the way she did in the military.

> I was never tiny, tiny, but I was always athletic and pretty muscular. And I stayed active. And now you know, it's just, it's different, I guess. Because I will say, I definitely prioritize my family over myself. I don't make a ton of time for self care. And when I do, it doesn't end up being in the form of things that will make me smaller.

As her focus shifted to her children, her ability to spend the time on maintaining a smaller body was gone, though she expressed sadness over this fact. As mentioned earlier, Gillian's doctor recently prescribed weight loss pills to account for the time she is not able to spend getting smaller. Sara and Gillian both faced external and internal pressure to focus on becoming smaller

in these spaces. The emphasis was on their physical bodies, and not necessarily their health (Strings 2019).

For Emily, a single mother of one, discussing exercising has become a way to teach her child about disability and body differences.

> I'm sure being fat impacts my mothering. My son is really into exercise right now in school. He likes to run and has started saying things like 'we need to run for our bodies'. I've been telling him that there are different types of exercise and that not all bodies can do the same types of exercise, and that there isn't a good or right way to exercise. I went to a yoga class last week and I made sure to tell him about it because I want him to know that I can also exercise and move my body even if it isn't running. I try to really reinforce that.

While Emily did not feel as though her son's interest in exercise was anti-fat, she reiterated the fact that she wanted to instill in him a weight neutral approach to fitness. She mentioned that she knew this would be different from the messaging he would receive in other spaces.

Several mothers I spoke to discussed the ways they actively try to disentangle anti-fat biases from exercise for their children in order to break the cycles they were a part of in their families of origin. Susan makes sure her child doesn't see exercise and food together.

> I don't want my child to think exercise is a punishment. You know, her favorite thing is fucking running. And if I told her, 'you have to do it because you had a cookie three days ago', it would no longer be her favorite thing, because she would look at it as a form of punishment, which is what I was trained to do. It took me so long to love to move my body…My kid will not go through that.

Using exercise as a way to punish and police people of any size can contribute to a multitude of harmful outcomes, including the internalization of anti-fat bias and the perpetuation of harmful weight stigma. Susan explained that when she was growing up any time she ate 'junk' or 'bad' food she had to 'make up for it' by either eating less or exercising it off. Weaponizing exercise as punishment can lead to the development of eating disorders and unhealthy relationships with food when individuals are pressured to maintain a certain body size or weight. The experiences of mothers like Susan highlight the need to actively work towards disentangling exercise from anti-fat biases in order to break harmful cycles that can perpetuate through families and generations. By consciously creating an environment where exercise is not linked to shame or guilt, but rather to enjoyment and wellbeing, Susan is helping her child develop a more positive relationship with their body and exercise.

The feeling that the exercise they were doing wasn't 'real' enough or 'good' enough came up several times in other conversations, as well. For example, Nena discussed how hard it is to keep up with young children and expressed her desire for higher endurance.

> That kid is…wow. I need to exercise more so I can keep up with him. I don't think it would matter what your weight is, playing in the pool for three hours is taxing for anybody! So maybe I need to do some squats or something. I don't know. My thighs are killing me. Being in the pool is a workout for sure, and you don't realize it until you get out when you think, 'oh my god, I can't walk!'.

A little while later in the conversation Nena brought up how she wishes she could be more focused on nutrition and exercise. When I pointed out she had just spent three hours in the pool with her child she laughed and said, "oh, right." Interestingly, mothers' talk of exercise

occasionally included only the exercise their children were doing. Josephine's child recently started playing in a community soccer league, and she attends all practices and games with him.

> I immediately feel out of place when I arrive at the games and the practices because all the parents are, you know, much thinner and more fit and, and seem younger, but I don't know if I'm projecting that. I realized I needed to order a chair because there was no real place for me to sit or be comfortable. So I had the experience of looking up folding chairs, making sure they had enough capacity and were comfortable… The big reason we're doing this is that I want him to learn some sportsmanship. But in my head I was worried other parents were thinking, 'oh, the kid that doesn't run has a fat parent!' Suddenly I was very aware of, and wondering what the other parents were thinking about me because of him. That's something I don't like to do. I don't like to invest my vanity and ego in my children. I don't like to see them as reflections of me because that's bullshit. But I still found myself doing that and then getting embarrassed.

Josephine's worry about what other parents may be thinking about her and her child highlights the internalization of anti-fat bias and the fear of being judged and excluded based on her body size even though she is also acutely aware of what is happening in that process. Josephine's concern that other parents may be attributing her child's lack of running to her fatness suggests that she feels responsible for her child's behavior and performance, and that she anticipates being blamed or shamed for it. This reflects the way in which fatness is often pathologized and treated as a personal failing or a moral issue (Murray 2008), especially when it comes to mothers and their children. Josephine is enduring this shame to allow her son to continue playing soccer. Perhaps this has to do with the fact that she is not as on display as Jessi

was while wearing a swimsuit, or perhaps because she has internalized principles of intensive mothering. She may find that she needs to prescribe to intensive mothering to both deflect potential negative comments about her mothering and to ensure her son is provided the same opportunities as other children.

The feeling that mothers' fat bodies didn't 'fit' in these spaces continued (Lupton 2012 and LaMarre et al. 2020). In our second interview, Laura brought a baby wrap and hiking boots for the Toy Box.

> My wife and I have been adamant that we would use this wrap as long as our kids would let us. When a kid is worn it really helps build connections…We wanted to be more active and get our kids out enjoying nature, so we go on a lot of hikes. I have these super ugly hiking boots. They're the ugliest. I stole them from my mom [Laura laughs]. I would never buy myself hiking boots because I have this internal monologue of 'you don't hike enough, you wander in the woods at a slow place and are too lazy to climb things, you don't deserve them'...

Even though hiking is an activity Laura enjoys with her whole family, as well as an activity that many perceive as athletic, there is an element of internalized fatphobia stopping her from believing she is 'worthy' of buying appropriate hiking gear for herself. Not wearing the appropriate gear in this situation could lead to acute or chronic injuries. Additionally, it could act as a deterrent for engaging in the activity at all. Laura doesn't identify as a hiker even though she frequently hikes. This reflects a hesitation to claim an activity that is typically coded as a 'thin' activity. Laura continued:

> Anyway, I decided I was going to wear these because they're hilariously serious hiking boots. Now I don't have an excuse to not go hiking! My wife started doing

> research about the wrap and told me she was worried she was too fat for it. So we kept doing research and found out that they do make an extra large one. But we were like, why not add a few extra inches to all of them and make it easier for anyone? The base price for the carrier we got was around $120. I'm not rich, child care is stupid expensive, so I have two kids that have stayed home with my wife their entire lives because it's cheaper for me to be the only one getting paid right now. So it's just like man, why, especially when you're buying a hundred thousand other things do I have to pay for that extra extender. If you want one that is going to fit a larger body you have to pay more and get it from a company that is already more expensive because of the quality. It was one of those awkward, kind of sad moments, but also nice to see a company being at least a little more cognizant of making things for larger parents…We try to do a weekly hike when it's nice out. Whenever I tell people, I always qualify it with 'we went on a hike but it was only half a mile, and we don't really go uphill, and we mostly just wander around'. But why do I do that? I know why, you look at me and you do not see a hike-ey, outdoors-ey person. I feel like I need to explain myself. But what am I teaching my kids when I do that?

Laura sees that her internalized fatphobia is impacting how she relates to hiking and how that impacts her children. These kinds of qualifiers ("it was only half a mile", "we don't really go uphill") Laura uses when telling people about their family outings are implicitly teaching their children that being fat makes it difficult or impossible to fully, truly engage in physical activities like hiking. This can later create a sense of shame and self-doubt in the children, who may begin to believe that their own bodies are not capable of being active or enjoying outdoor activities if

they are also fat. While people of all sizes may be wary of claiming they are 'really' hikers, Laura explicitly notes "you look at me and you do not see a hike-ey, outdoors-ey person" which underscores her fear that fat and fit do not go together.

Sara, a fitness instructor and mother of two, brought her water bottle to our second interview as her contribution to the Toy Box.

> It's kind of silly, but I always have a water bottle with me almost everywhere when I leave the house. It's sort of the representation that I carry with me into the world that shows who I am and what my interests are. I have my *strong, athletic, and fat* sticker, my Radical Health Alliance sticker, it says *championing health for fat people…* I have my super fat hero sticker that says *I work out because I love my body not because I hate it* and I have a *body love* sticker, and I have my *wander free and queer* sticker.

Sara talked about how having these stickers showing different parts of who she is was very important to her. As we continued the conversation, she mentioned the other item she thought about bringing was a graphic t-shirt that says '*strong athletic mom,'* which she often wears to her job as a fitness instructor.

> I'm always happy to talk to people and I think there's something about carrying that water bottle that…I do choose to carry this because it has a lot of messaging about being fat and fit… I know there is a lot of fatphobia and especially when you engage with people and the way they talk about their bodies and fitness. They'll talk about movement as punishment or something you're obligated to do to make up for the extra calories you ate…I love that people know that I'm an aerial instructor, I'm a mom, and I'm happy with my body.

I asked Sara if they ever felt nervous having the stickers on their water bottle in public.

> I still haven't ever had anybody actually, like, come up to me but I am on guard. I know that pushback exists in the world. When I was younger, I would engage but now I just know that people are going to have their opinions and I can't change them. I am cognizant of when I make the decision to go out into the world advertising these things. I have that internal dialogue where I wonder what I'd do if someone pushed back against the message I'm sharing. It never ends up actually happening the way that I worry it will, but because I have experienced so much systemic fatphobia in different aspects of my life, especially medically, I am always on guard. When those things happened to me in my 20s I was so ashamed, deeply ashamed of being a fat person. I didn't want to be acknowledged as a fat person. When I got pushback or fatphobia I would shut down and cry, it was always deeply embarrassing…I'm not looking for a fight but I think it would be easier for me to verbally tear someone to shreds. I have more data and evidence in my corner.

The fact that Sara discusses how she is always prepared to have a talk with someone who questions her water bottle and stickers, demonstrates anticipated futures. It also demonstrates that fat mothers cannot use exercise for what many people do: stress relief and freedom; rather, fat shaming follows them into their active spaces, operating as a mechanism of control that continues to discipline their bodies.

Summary

Being a fat mom involves navigating a complex web of issues that can impact mothers' confidence and sense of belonging. To further explore the complexity of fat motherhood, this chapter delved into several key themes that shape the experiences of fat moms. They include breastfeeding, how the mothers felt about their fatness, how their fatness shaped their experiences day-to-day, and exercise.

Breastfeeding can be challenging for fat moms due to societal expectations around weight and body size. The pressure to feed their families after becoming mothers is not only about providing food for their children but also affects their sense of identity. The medical (and social) narrative that breastfeeding prevents fatness in the breastfed child and causes weight loss in the mother perpetuates weight stigma and adds an extra layer of complexity for fat mothers (Breastfeeding 2021). Strategies and resources for supporting fat moms in breastfeeding are necessary to address these challenges.

Several mothers shared stories of being ridiculed or shamed for their body size throughout their childhood and into the present, with lasting effects on their lives. This is another reason why it is crucial to view the journey of motherhood as a continuous thread linked by anticipation. This chapter also covered the ways anti-fat anticipatory regimes hold mothers accountable for their own and their children's weight, leading to generational stigmatization. Mothers described feeling constantly judged in public, highlighting the "panopti-mom" phenomenon where mothers are subject to the gaze and judgment of others (Murray 2013). Mothers also discussed their resistance through courageous behaviors (e.g., wearing a bikini to a public pool)--which, consequently, often sent mothers back to their marginalized spaces.

Mothers reflected on their interactions with healthcare providers, including discussions of dieting and weight loss surgery (WLS) as a potential solution. Mothers also discussed the fear of a fat future for themselves and their children, with weight loss efforts ranging from dieting to medication to considering WLS. The fear of not being around for their children was frequently expressed, whether it meant literal life and death or being around in a way that is only appropriate for thin people.

Mothers experienced shame, guilt, anxiety, and apathy while navigating fitness and exercise, which they tied to their bodies, futures, and worthiness. Mothers also attempted to break anti-fat patterns in exercise spaces for their children, as it was their duty to protect their children from the stigmatizing experiences they had growing up. It is clear that fat motherhood involves navigating a web of issues that can significantly impact their sense of confidence and belonging. The experience of fat motherhood is ultimately reflected in these interrelated issues.

Amidst these complex issues, some mothers embrace fat positivity, while others struggle with feelings of shame and the desire to lose weight. It is important to recognize that though these mothers are making their own decisions about their bodies, these decisions occur within a structural context of anti-fat messaging that can have various degrees of micro-subtlety. Ultimately, it is crucial to support mothers in making their own choices about their bodies while also working to challenge and dismantle the institutions that perpetuate fat stigma and inequality.

CHAPTER SIX: CONCLUSION

In conducting this study, there were two main objectives. The first one was to uncover the ways in which weight stigma impacts motherhood by providing an in-depth analysis of self-identified fat mothers who had children between the ages of two and ten. The second objective was to highlight the significance of weight stigma as a form of inequality that is often overlooked, especially in relation to the experiences of becoming and being a mother. Brianne's experience with her mom group highlights a central theme of this dissertation, that the impact of weight on the intersectional experience of motherhood must be considered. While thin mothers undoubtedly face many forms of discipline and inequality, especially for thin mothers with other marginalized identities (e.g., queer), fatness creates a unique impact on motherhood in the United States. Indeed, fat mothers operate under the panopi-mom, where they are overtly judged or they perceive other mothers to be gazing at them–and making assumptions about their health and parenting. Brianne's story also illuminates the fact that formally talking about fatness and anti-fatness resulted in fat mothers reevaluating their experiences and processing how they relate to them. And, as in Brianne's and Jessi's cases, they alter their behaviors and become more isolated.

Fat mothers are often superficially seen through the lens of anti-fat stigma and bias, which positions them as out of control, lazy, and incapable of making responsible decisions. However, when it comes to medical care, for example, fat mothers are often neglected or dismissed, which can lead to serious health consequences for themselves and their children. As evidenced in this study, healthcare providers may assume that any health issues a fat mother experiences are solely due to her weight, rather than conducting thorough medical evaluations to identify and treat underlying conditions.

At the same time, fatness is often seen and immediately judged, leading to increased surveillance and testing for fat mothers during pregnancy and childbirth. This can be a form of medicalization and stigmatization, as fat mothers are forced to submit to extra testing and interventions solely because of their weight, rather than because of any actual medical need. As all of the stories in this dissertation illustrate, the experience of motherhood in the United States is complicated by a multitude of intersecting identities including weight, race, gender, ability, age, sexuality, and class. The United States is one of the least safe places in which to have children when compared to other "high-income" countries, with a maternal mortality rate of 32.9 deaths per 100,000 live births in 2021 (Simmons-Duffin and Wroth 2023). When broken down by race, Black women had a maternal mortality rate of 69.9 deaths per 100,000 live births, which is 2.6 times higher than the rate for white women (Simmons-Duffin and Wroth 2023).

Anti-fat discrimination occurs within a larger context of the United States being one of the least safe and healthy places for people to bear children. From Melissa's experience we learned how anti-fat bias almost meant death for the new mother. Her newborn's handprint on her chest was a warning sign that something was terribly wrong. Even though her OB thought she was in a medical crisis, the urgent care doctor dismissed her symptoms and sent her home with a diuretic. Messages: You are just fat. Exercise more. This prompted Melissa to adopt a "keeping up" attitude, much like poor mothers in *Promises I Can Keep* adopt a "being there" parenting paradigm. "Keeping up" is similar to "being there" in that it was Melissa's way of resisting notions that she was a bad mother, but also it created the space for her to be the mother she could be. Melissa's experience highlights the urgent need for intersectional analysis in sociological research on mothering as unequal motherhood in the United States has devastating

consequences. The experience of mothering is not the same for all women, and mothers from marginalized communities often face compounded forms of oppression and discrimination.

While the transition to motherhood is likely difficult for all mothers, many of the mothers in this study expressed added stress due to weight stigma. Because their bodies were read as "out of bounds," often mothers' concerns were ignored (as was the case for Brianne who knew her baby was not moving) and their autonomy stripped (as was the case for Maria who had to coach her husband on being strong and refusing a c-section). Edin and Kefalas (2011) note that parents often experience a "magic moment" at the birth of their children. The mothers in this study are denied this celebratory moment, as their focus is often on their weight.

Some mothers also discussed the ways in which their queerness was not separable from their fatness. For Gemma and Sara, their queerness opened the door to bodily acceptance and fat liberation ideology. Other mothers, like Susan and Josephine, underlined the ways the intersection between being fat and of advanced maternal age played a large role in their mothering experiences. Susan even remarked at one point that it was hard for her to distinguish where fatphobia ended and ageism began in her experiences. Importantly, Susan holds a PhD in sociology and had the tools to analyze her own experiences alongside me. The fact that anti-fat discrimination occurs within this broader context underscores the urgent need to address systemic inequalities in maternal health and wellbeing.

We cannot continue to ignore fatness as a site of "hyper(in)visibility" in sociological research (Gailey 2014). Gailey (2014) examines the ways in which fat women are hyper-visible in some contexts and invisible in others. She argues that fat women are both hyper-visible, in that their bodies are often subjected to intense scrutiny and judgment (much like Jessi's experience at the pool), and invisible (in particular, Maria's experience of not being viewed as pregnant, even

by her husband and family, because of her weight), in that their experiences and perspectives are often ignored or marginalized. Some mothers even discussed how they navigated spaces where they thought their bodies would be less visible, but were caught off guard when they experienced hypervisibility (which was evident in Allana's experience when she served as a substitute teacher and a pupil pointed out her fat body). The inverse was true, too. Emily discussed how she felt like she would be hypervisible as a fat person when meeting with her new IVF doctor, but her doctor focused simply on *when,* not *if,* she would conceive–a type of invisibility that gave Emily hope that she might become a mother. Regardless of each mother's anecdotal experience, the pattern demonstrates that mothers constantly operate under the panopticon–where their bodies are surveilled in both overt and covert ways.

Fat mothers experience a paradoxical situation where they are superficially judged and stigmatized for their weight, but are also neglected and marginalized in terms of medical care. In the context of anti-fat anticipatory regimes, power and authority play a significant role in shaping experiences of fat motherhood. Fat mothers may experience a sense of powerlessness and a lack of agency within these systems, as they are constantly subjected to surveillance and scrutiny from various sources positioned as authorities. As Gailey (2014) writes, this is compounded for those who are also members of marginalized communities, and are often subject to multiple layers of discrimination and stigma.

Indeed, this surveillance can come from healthcare providers, who may stigmatize fat mothers and assume that their weight is the cause of any health issues they may experience. But it can also appear in more unassuming places, like it did for Jessi when her four year old student made an anti-fat comment about her body. Jessi was in a position of authority and power as the adult and teacher, but her student's comments disarmed and disciplined her. Jessi's experience

highlights the power of weight stigma and internalized fatphobia. The anti-fat sentiment expressed by Jessi's student came from adults and the world around them: we socialize children from an early age to police bodies out of bounds.

The findings of this sociological dissertation reveal an important aspect of the discipline related to body weight and size. Despite several mothers' attempts to instill weight-neutral attitudes in their children, discipline was upwardly transmitted from the children to their mothers. Not only were the mothers subjected to intense scrutiny and judgment from others outside the home, some of their own children were beginning to display anti-fat behaviors.

This study suggests that the surveillance and discipline experienced by these fat mothers are not just coming from other mothers (i.e., the panopti-moms Murray [2013] referenced), but from everyone. In fact, the judgment mothers reported was amplified to a panopticon-like level. Mothers reported that they perceived no place or relationship to be free from anti-fat bias, which led mothers to engage in self-surveillance and discipline. They operated under a constant gaze–which meant that some mothers altered their movements and residences to attempt to avert this gaze.

The intergenerational transmission of discipline related to body weight and size is complex and multifaceted. Future research should continue to explore the ways in which fatphobia and anti-fat bias are perpetuated and transmitted intergenerationally, and the potential long-term consequences of this transmission on both mothers and their children. To gain a complete understanding of the impact of anti-fat bias, it is imperative that we pay attention to its intricacies and nuances. Fatness must be understood as a site of inequality.

This dissertation makes two unique contributions to the field of sociology; first, that anticipation connects the experiences of motherhood in significant ways. When I started this

project I intended to focus on the years following the moment of becoming a mother. What I learned very quickly, however, is that those moments of becoming are often at the core of what is happening later. Without making room for those past moments the present cannot fully be understood. In the same vein, it is important to understand the ways in which these mothers are constantly looking to the future with hope and fear. What has already happened and what might happen both impact what is currently happening. In realizing this, I also found that these interviews functioned as a space of processing for the mothers. Several made off hand comments about how they hadn't realized how much these moments from the past were still impacting their lives today. Moreover, the interviews were often punctuated with profound emotions, spanning the range from gales of laughter to moments of sadness and tears. The mothers I spoke with had been deeply conditioned to think that their body was an active threat to their child(ren).

The anti-fat messages encountered by mothers were multifaceted, ranging from external micro-aggressions such as ill-fitting medical gowns and subtle comments, to more overt and hostile interactions–which many of the mothers internalized. In some cases, the anti-fat messages made it into their own households, perpetuated by their partners and children. This placed a huge weight on their shoulders and the emotional toll was clear. Under the guise of 'caring', messages came from everywhere to spell out the reasons they were unfit to mother in their fat bodies. For some, this body disappointment had begun accumulating in childhood but became inescapable when their journeys to and through motherhood required a higher level of engagement within the medical establishment in particular. This reveals a specific tie between anti-fat bias and motherhood. It also demonstrates that fat inequality is interactional, as many of the mothers expressed feeling the burden of weight stigma as they navigated institutions. However, it was interesting to see the ways in which having children themselves relieved the pressure and

allowed for more joy in the mother's relationships with their bodies. Perhaps mothers felt confident that their relationships with their children would be free of anti-fat bias, as they would be their children's agents of socialization. Unfortunately for some mothers, their children's own exposure to institutions led to increases in fatphobia.

Second, talking about fatness and anti-fatness can change the way fat mothers feel about their lived experiences. Melissa, a married mother of one, commented that she felt like one of the "Forgotten Ones" when it came to her experiences as a fat mother. She said this was because she had yet to find any spaces open to the kinds of discussions we had together. I found that simply making the space to talk about fatness and anti-fatness had a significant impact on how these mothers felt about their lived experiences. Throughout this study, I found that most of the mothers I interviewed experienced deep-seated shame and guilt about their bodies, particularly in relation to motherhood. This shame was often the result of constantly reinforced anti-fat ideology. By creating a space for these mothers to discuss their experiences with fatness and anti-fatness, the mothers processed their feelings and some expressed a deeper understanding of how these cultural messages had impacted their everyday lives. Additionally, in many cases these spaces worked to frame fat stigma as an important (but often unacknowledged) form of inequality.

Another important component of this was the time in between each interview. The mothers had time to step away from our conversations and chat with their partners, their children, friends, and doctors. In some second interviews mothers reported that they had had fruitful conversations with those close to them about things discussed in the first interview.

Some mothers, as Melissa said above, expressed that simply being able to share their stories with someone who understood (as a fat person) and validated their experiences was a powerful tool for healing.

The Toy Box

I have always been interested in the stories that objects can tell about a person's life. I decided to incorporate this into my methodology by asking participants to bring an item or items of importance to the second interview that represented their experience of motherhood specifically related to their body and weight.

I gave participants the freedom to choose whatever item they wanted to bring, and during the second interview, I asked them to tell me any stories about the item, why it is important to them, and how it makes them feel about motherhood and their body. This allowed me to gain a deeper understanding of their experiences and their relationship with motherhood. Artifacts contributed to the Toy Box included clothing items, photographs, furniture, jewelry, a minivan, breast pumps, baby carriers, breast feeding pillows, and more (Steeves and Simonetto 2019).

By using this methodology, I avoided imposing my ideas of importance on the participants and instead allowed them to show me what was important to them as (fat) mothers. This resulted in a variety of meaningful items brought to the second interview, which helped me to gain a more nuanced understanding of their experiences. The mothers were excited to talk about the items they brought and overall this methodological approach worked very well. Some mothers were hesitant when first showing me their objects as they weren't sure if it was exactly what they thought I would want. This illustrates the extent to which most interviewees want to be "good" interviewees (perhaps parallel to their desires to be "good" mothers). Some mothers said

things like ‘this might be stupid’ or ‘I know this seems silly but…’ which does highlight the power imbalance inherent in research that positions me as the authority. After I immediately reassured them that the items were great submissions, there were no further apparent feelings of unease.

I did not include any photographs of the artifacts in my dissertation to ensure that the mothers alone interpreted the artifact and its importance to them though I do include descriptions of all items in chapter three. Future research should consider including photographs as they could bring another layer to this methodological approach (Harper 2002).

Overall, this methodology was incredibly effective, moving, and seemed to empower the mothers that participated. The Toy Box stories became a central part of my analysis, and I believe that this methodology can be applied in other research contexts to enhance the relationship between researcher and participant and allow for a deeper understanding of the lived experiences of individuals.

Limitations and Future Research

While this study provides insight into the lives of 18 fat mothers across the United States, the findings can not be generalized to all fat mothers, though generalizability was not a goal of this particular project. The goal of this particular study was twofold. First, to provide an in-depth analysis at these particular mothers at this particular point in time in order to uncover the ways in which weight stigma impacts their experiences of motherhood. Second, I aimed to illustrate that weight stigma is an important and impactful but often unacknowledged form of inequality, particularly around the experiences of becoming and being a mother.

Future research should include a larger and more diverse sample of mothers. Specifically, this sample was primarily comprised of white, biological mothers. Twelve of the 18 mothers held an undergraduate degree or higher. Only three mothers described themselves as upper middle class, while the remaining 15 self-reported class status as middle class, lower middle class, and poor. Three mothers were single and four identified as part of the LGBTQ community. In order to see a more complete picture of fat motherhood, future research should include more adoptive and step-mothers as well as a more racially diverse population. A longitudinal study following mothers as their children age would provide a better understanding of how anticipation of the future lines up with their eventual realities. There is much work to be done to understand intergenerational weight stigma and the impact of anti-fat bias in the family. Additionally, future research in fat studies more broadly would benefit from understanding the implications of anticipatory regimes in anti-fat bias.

Policy Implications

There are a number of policy initiatives that may benefit the fat mothers I spoke with. Generally, a lack of evidence-based, weight neutral health care and medical interventions negatively impacted every mother and/or their child(ren). One way to remedy this issue is by implementing national standards of care for treating fat patients from a weight neutral standpoint. This could be achieved through weight focused anti-bias training and a reevaluation of medical approaches to weight more generally.

In a survey of 40 medical schools in the United States, only 10% of schools reported that their students were “very prepared” to manage fat patients in clinical settings, while a third of these schools reported having no weight-based education programs in place (Butsch et al 2020).

Butsch et al. (2020) also found in schools that provided weight-based programming only an average of ten total hours were dedicated to this topic, which explains the finding that half of the surveyed medical schools thought weight-based education was a low priority or not a priority at all (Butsch et al 2020). What may seem like an obvious systemic fix, simply increasing weight-based instruction hours in medical schools, is not so simple. Geller and Watkins (2018) attempted to reduce medical student anti-fat bias through ethics focused education. This team found that physicians, including those in primary care and those who specialize in treating "obesity", and medical students, commonly hold anti-fat biases (Geller and Watkins 2018). To address this issue, they attempted to integrate ethics and professionalism objectives into courses on nutrition, providing students with the opportunity to reflect on the unethical and unprofessional nature of such attitudes and behaviors towards fat patients. Four months later, more than 50% of students reported no change in their feelings about fatness, 10% of students reported having more negative attitudes about fatness and 30% reported a positive change in their feelings toward fatness (Geller and Watkins 2018).

While medical institutions will undoubtedly continue to have weight-based policies, compassionate and respectful care from medical professionals is essential for providing equitable treatment to fat patients (Puhl and Heuer 2012). One such way is moving away from the medicalized terminology of 'overweight' and 'obese', and instead opting for 'fat' as a neutral size descriptor. At the time of writing, only Michigan and Washington have laws that protect against weight-based discrimination. It is worth noting that weight is a protected class in Washington only because the state classifies 'obesity' as a disability. Federal laws protecting against weight-based discrimination are necessary for both individual protection and shifting macro-level anti-fat rhetoric.

From a consumer standpoint, a lack of affordable, easily available extended size baby wearing devices, maternity clothing, and other items related to the care of their children placed an unnecessary financial and emotional burden on the mothers I spoke with. Companies offering these products should expand their size offerings to include both very thin and very fat parents who may need their items. If substantial, systematic changes are not made, fat mothers and their families will continue to face inequality in all areas of their lives. Some children may even experience the death of their parents early in life due to medical malpractice, which would likely increase their risk of instability across the life course.

People have children every day. It is not uncommon nor unusual to engage in mothering whether it is social or biological. It is not even uncommon to be a fat mother. If we use predominant measures of weight (like the BMI), most mothers in the United States today are fat. Unfortunately in the same vein, it is common to hold anti-fat bias regardless of one's size. Viewing fatness through a sociological framework illuminates weight as a site of inequality. This study attempts to show the ways in which these anti-fat biases have, and continue to, impact the lives of fat mothers in an anti-fat social world. Through sharing the stories of these 18 mothers, I highlight the everyday-ness of anti-fat bias and how it has so far shaped the lives of these mothers in very significant ways.

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APPENDIX A: Interview questions for the first interview

Introduction

I am writing my dissertation on how weight may impact the experience of motherhood. I will be recording this conversation. This is so I can be fully present during our talk, instead of taking too many notes. I may still occasionally jot something down. I use the word 'fat' to describe myself in a neutral way. If I use the word 'fat' during the conversation, it is not in a negative or derogatory manner. I also want you to know that I am here as a learner. You are the expert. I will be asking general questions about your experience as a mother, but please talk about anything you think is important to discuss. You do not have to answer any question that you don't want to, and at any point we can end the conversation. Your privacy will be protected with a pseudonym. Are you ready to begin the interview? Let's begin with general information about you.

1. Tell me a little bit about yourself.
    - How many children do you have?
    - Are any of your children biologically related to you?
    - Are any of your children related to you through marriage, partnerships, or other social relationships?
    - Tell me about being a mother. What does a typical day look like for you?
    - What did a typical day look like for you before you had children?

I'd like to ask you a few questions about your body and weight. I know that these are very sensitive questions, you do not have to answer any of them.

2. Tell me about your relationship with your body
    - What do you like about your body?
    - Is there anything you don't like about your body?
    - What is your relationship with your weight?
    - Have you ever had experiences that you would consider connected to your weight specifically?

3. Pregnancy (if they carried any of their children)
    - What kinds of conversations did the people around you want to have once you became pregnant/decided to have children?
    - Once you became pregnant, did your relationship with your body change? (For example, did you start a new diet, did you notice physical shifts)

I'd love to hear about what motherhood is like for you.

4. Have there been any moments that have shaped your experience as a mother?
    - How is your experience of motherhood similar to other mothers around you?
    - Dissimilar?
    - Is your experience as a fat/plus size mother the same as mothers who aren't fat/plus sized?
    - How did your expectations about becoming a mother compare with the reality?
    - If you could go back in time to visit yourself before becoming a mother, what would you tell yourself?

Now I'd like to ask you some questions about your relationships and parenting.

5. Are you in a relationship?
    - If in a relationship: Do you raise the children together? Tell me about raising your child(ren) together.
    - Have you felt pressure about your body from your significant other since becoming a mother?
    - If single: Are you dating or pursuing a relationship? If yes: ask, how has dating or pursuing a relationship changed since becoming a mother? Do you feel pressure about your body while pursuing a relationship?

Let's discuss any parenting or mothering communities to which you belong.

6. Do you have any experiences that stand out from your parenting/mothering communities?
    - Do your mothering/parenting communities ever discuss weight? What do those conversations usually look like?

I'd like to know what you think about mothering in general.

7. What is a good mother, in your opinion?
    - Do you know anyone that qualifies as a good mother based on these criteria?
    - Do you consider yourself a good mother?
    - Describe what a bad mother would be like.
    - Does weight or body size ever factor into any of this?

APPENDIX B: Interview questions for the second interview

1. Is there anything you'd like to revisit from our first talk?
2. Since we last met, have you had any experience related to our first interview?
3. Did you bring anything to discuss?
    - Tell me why you chose [state item] to bring today?
    - How, specifically, does it represent mothering to you, or influence your maternal identity?
    - Describe to me the feelings you attach to this item
    - Did you consider bringing other items?

I'd like to ask you about how you talk to your children about beauty standards
Do you have conversations with your child about beauty standards?

- If they are old enough, does your child talk about your body? (If yes, ask, are they negative or positive comments? What comments are they making?) How does this make you feel?
- Do you feel like there are expectations for your children's bodies? Their weight?

Now I'd like to discuss food and mealtime in your family.
What does mealtime usually look like for your family?

- How do you talk about food in your household?
- Do you feel any pressure to eat a certain way now that you are a mother? Did you feel this before becoming a mother?
- Do you think your experiences of mealtime and feeding the family are different as a plus size/fat mother?

Is there anything else you think I need to know or understand? This could be related to anything we've discussed or anything I've missed.

APPENDIX C: Pre-screening Questionnaire

1. Do you identify as a mother, either biological or social (social meaning that you became a mother through a relationship, not biologically)?
    - Yes
    - No
    - If yes, please specify between biological and social _____
2. Do you actively parent a child(ren) between the ages of 2 and 10?
    - Yes
    - No
3. Do you identify as fat or plus sized, or have you been diagnosed as “overweight” or “obese”?
    - Yes
    - No

APPENDIX D: Themes

Theme	***# of Respondents who Mentioned***	***Respondents who Mentioned in Relation to Fatness or Anti-Fatness***
Fertility Treatment	11	9
IVF	10	9
PCOS	10	10
Adoption	7	2
Pregnancy	18	18
Looking the Part	7	7
Loss and Grief	7	5
Birth and Postpartum	16	15
Breastfeeding	16	14
Feeling Fat	18	18
Fat in Public	16	16
Weight Loss	10	10
Fitness and Exercise	10	10