"Constantly justifying my existence": Lower-income, higher-weight Canadian adults' stigma coping mechanisms

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ABSTRACT

Individuals who are higher-weight and low-income may disproportionately experience weight and income stigmas in healthcare experiences compared to lower-weight, higher-income individuals. The ways that weight and income stigmas interact in healthcare should be better understood in order to provide better, less stigmatizing care to higher-weight, low-income patients. This study assesses how patients manage stigmatizing experiences in both healthcare and everyday experiences and how that impacts health seeking and stigma management behaviors through semi-structured interviews with 11 higher-weight (Body Mass Index ≥30), low-income adults (≥18 years of age) in an Atlantic Canadian province. Participants took part in two interviews that focused on healthcare experiences and both positive and negative places/spaces. The two face-to-face interviews for each participant (total 21 interviews) were audio-recorded and professionally transcribed verbatim. The transcripts were analyzed using thematic analysis to identify recurring concepts and patterns within the data. Two major themes emerged from the data, *uptake of stigmatizing, neoliberal health messaging* and *coping with stigma*. *Coping with stigma* included subthemes *control over stigmatizing experiences* and *stoicism in the face of stigma*. The findings suggest that individuals understand their health and wellness through a neoliberal lens and that they deploy strategies of control and stoicism to cope with the stigmas they face.

Introduction

Weight stigma most often affects higher-weight individuals and can have negative impacts on the mental and physical wellbeing of those who experience it (Puhl et al., 2008; Puhl & Heuer, 2009, 2010). When accessing healthcare, higher-weight individuals are often negatively stereotyped due to their weight and seen as being non-compliant or being weak-willed (Rich & Evans, 2005; Puhl & Heuer, 2010). Higher-weight individuals can be subject to experienced and/or internalized stigma. "Experienced stigma" refers to instances where individuals are treated negatively due to their weight (Mensinger et al., 2018). Comparatively, "internalized" stigma is "self-directed, personalized, and afflicted towards oneself" (Mensinger et al., 2018, p. 140). Similarly, it is well documented that having lower income is associated with both experienced and internalized stigma and that these experiences with stigma impact the delivery of healthcare to this population (Allen et al., 2014). Low income is an established predictor of negative health outcomes and is understood as one of the key social determinants of health (Raphael, 2016).

A paucity of literature exists addressing intersecting stigmas experienced by those living on a low income who are also higher

weight.[1] Weight and income stigmas may operate concurrently and intersectionally (Colls & Evans, 2014; Kirkland, 2011). These processes may negatively impact health outcomes and overall wellbeing of higher-weight, low-income individuals. However, current understandings of class and weight often reinforce classist stereotypes, such as the assumption that low-income people are unaware of how to care for themselves and do not adequately address the true risk factors of poor quality of life and health outcomes (Farrell et al., 2016; Gard & Wright, 2005; Kirkland, 2011). Furthermore, neoliberal ideals that frame health and wellness as matters of personal choice and responsibility further stigmatize higher-weight, low-income individuals (McGregor, 2001). This analysis aims to illuminate the self-determined narratives of higher-weight, low-income individuals in healthcare and everyday experiences to highlight how the participants talk about their own health and healthful behaviors and how to reduce stigma in healthcare for higher weight, low-income individuals.

Critical weight studies

As a discipline, critical weight studies draws from foundational work in critical theory. Critical theory is derived from multiple disciplines of Western social, political, and philosophical thought and serves to problematize and dismantle dominant, often untrue, social narratives (Bronner, 2011; Devetak, 2012; Russell, 2024). While critical theory is not one distinct methodology, it offers a foundation to critique unquestioned beliefs about society that are often seen as neutral and "common sense" and contribute to oppression and inequality (Ryoo & Crawford, 2023). Practitioners of critical theory are deeply skeptical of these narratives and attempt to expose and transform the relationships and structures of power and domination that are present when new knowledge is produced and incorporated into society (Devetak, 2012; Ryoo & Crawford, 2023). In the social sciences, such a theoretical lens encourages researchers to be more reflexive in their practices by critiquing the biases through which scholars interpret the world and social phenomena (Bronner, 2011; Ryoo & McLaren, 2010).

Critical weight studies challenge the dominant, biomedical "obesity" discourse (Cooper, 2010). Critical weight scholars reject the view of a fat body as always pathological (Cooper, 2010) in light of increasing evidence of complexity in the relationships between fatness and health and doubt concerning the benefits of ubiquitous promotion of (very often transient) weight loss (Bacon & Aphramor, 2011; Monaghan et al., 2022). As a discipline, it problematizes the lay and medical perspective on the "obesity epidemic" by demonstrating where the scientific evidence surrounding the "obesity epidemic" is overlain with moral assumptions. Such assumptions include the idea of having "good" or "bad" exercise and eating habits and/or fat people being lazy and having poor character (Gard & Wright, 2005). This juxtaposes the normatively "healthy" body as being morally worthy of citizenship and care compared to the fat body, which is seen as unworthy and immoral (Monaghan et al., 2022).

Weight and income stigmas

Stigma is a concept derived from Goffman's social theory, which refers to the othering of marginalized individuals as non-normative (Bombak et al., 2016; Goffman, 1963). Stigma is typically a result of a mark or sign of disgrace that usually elicits negative prejudices, stereotypes, and attitudes directed towards its bearer (Thornicroft et al., 2007). The conceptualization of stigma used in this research recognizes structural barriers and institutional stigma in addition to interpersonal accounts of stigma. Mechanisms are developed in society that maintain power and the stigmatization of marginalized groups, which leads to discriminatory social hierarchies that continue to disadvantage those who are already negatively impacted by stigma (Harwood et al., 2022; Link & Phelan, 2001.

Drawing from Goffman's understanding of stigma, "fatness operates as a type of […] 'physical' and 'character' stigma," (Bombak et al., 2016, p. 95). Fatness as a physical stigma presents as negative perceptions of the body in a society that values thinness. Stereotypes associated with fatness, such as being lazy, indulgent, or immoral, are forms of character stigma, which are understood as perceptions of "weak will" (Goffman, 1963; Puhl & Heuer, 2009, 2010; Rich & Evans, 2005). Understanding weight stigma is particularly important because "weight stigma remains a socially acceptable form of bias" (Puhl & Heuer, 2010, p. 1019). Weight stigma can manifest in healthcare experiences, the workplace, education, mass media, and personal relationships. These stigmatizing experiences can have negative psychosocial implications, resulting in social isolation, diminished self-esteem, and poor health (Harwood et al., 2022; Puhl & Brownell, 2001; Puhl & Heuer, 2009, 2010).

While there is an abundance of literature regarding weight stigma, the majority of it is narrow in scope, leaving a gap in understanding how other marginalized identities intersect with weight stigma, including stigma faced by individuals living on a low income. Stereotypical attributes of higher-weight and low-income individuals can prompt stigmatizing beliefs about these individuals that are perpetuated both interpersonally and systemically (Durante & Fiske, 2017; Goffman, 1963; Puhl & Heuer, 2010). Research that focuses on lifestyle behaviors, like diet and exercise, rarely challenges elite norms of consumption and movement, like those that rely on paid exercise programs and access to nutritious foods, and often reinforces both weight and income stigma (Kirkland, 2011). This research does nothing to question the underlying classist assumptions about weight and income, including the false narratives that people living on a low income are necessarily less educated or unknowledgeable in terms of food preparation and diet choices and lack agency (ability to enact free will) regarding lifestyle choices and behaviors (Colls & Evans, 2014). Additionally, when ignorance is assumed among low-income individuals, structural barriers to good health are ignored. Instead, health-based interventions and policy decisions target education to address presumed ignorance (Farrell et al., 2016).

Intersectionality

Often, subordinated groups find themselves facing social problems that cannot be understood or solved in isolation from each other. Intersectionality, a concept originating from Black,

[1] "Fat" ("fatness") and "higher-weight" are used throughout this paper in reference to sociological ideologies, fat activism, and participants. These are used as neutral, not derogative, descriptors in line with fat activism and in an attempt to capture diverse language preferences among the group in question. "Overweight" and "obesity" are used when referring to literature coming from a biomedical approach. Quotation marks used for the latter throughout the article indicate the resistance these terms among fat activists (Meadows & Daníelsdóttir, 2016).

feminist scholarship, meets the needs of these groups as a developing critical social theory and analytical tool (Collins et al., 2021; Crenshaw, 1989). Intersectionality is a useful tool in discussing the lived experiences of multiply marginalized individuals and groups. Since its origins, the concept of intersectionality has been used to help scholars and activists discuss the interlocking nature of identity through a non-additive, social justice-oriented approach (Carastathis, 2014). Throughout this article, participants' lived experiences as multiply disadvantaged individuals are prioritized in the themes and patterns outlined.

Neoliberalism in healthcare and health messaging

Neoliberalism contributes to stigmatizing healthcare in Canada. As a political and economic theory, neoliberalism facilitates the replacement of "the concepts of public good and the community with individual responsibility" (McGregor, 2001, p. 84). This contributes to the social narrative that individuals are responsible for finding their own solutions to a lack of healthcare and that they have sufficient agency (capacity to exercise their free will) to enact these solutions. As a concept, neoliberalism often perpetuates the dismissal of systemic barriers that make healthcare inaccessible for marginalized people, especially those living on a low income. The personal, interpersonal, and social narratives surrounding health, such as the neoliberal understanding of health, are influential in the development of healthcare policies and practices (Raisborough, 2016). When individuals are seen as the main drivers behind their healthcare outcomes and experiences, already marginalized people, including higher-weight, low-income individuals, are disproportionately disadvantaged in healthcare policy.

Higher-weight, low-income individuals may be doubly implicated by neoliberal and healthist discourses as public health messaging pushes for individualized diet and exercise practices that are especially inaccessible for those living on a lower income (Godley & McLaren, 2010). Healthism, described by Crawford (1980), asserts that wellbeing is a matter of personal choice and responsibility to be achieved primarily through the modification of lifestyle behaviors, regardless of whether there is an external cause for disease or poor health. When individuals fail to meet the unattainable ideals for diet and exercise practices, and thus do not meet the neoliberal standards of embodiment, they may be further stigmatized. This can lead to the development of a particular narrative regarding individuals and their embodiment. Often, this narrative is rife with negative stereotypes and stigmatizing beliefs about the individual, which some may seek to control through stigma management techniques (Kaufman & Johnson, 2004). Narrative control, or the process of redefining stories and understandings of higher-weight, low-income individuals, as an aspect of stigma management and the uptake of stigmatizing beliefs will be explored throughout this paper.

In this analysis, the concept of a neoliberal ideology refers to its specific tenet of individualism and how it relates to health (Monaghan et al., 2018). LeBesco (2011) explained how neoliberal ideologies "responsibilize" individuals and forces the citizenry to make "good choices" for their health to avoid "obesity." Within capitalist societies, "industries make it rather unappealing to be fat, so much so that most fat people internalize this stigma and admit to a sincere desire to be thinner" (LeBesco, 2011, p. 260). This means that the state itself does not need to force people into thinness, but the stigma surrounding fatness marginalizes people who "opt out" of health, which is equated to thinness (LeBesco, 2011). The ubiquity and potency of neoliberal ideology pertaining to health was evident in the results of the present study, demonstrating that even those disadvantaged by existing social structures (those living on a low income) are not immune to the discourses underlying and helping produce them. This interpellation of neoliberal ideology was present among participants and manifested in controlling behavior, attitude, and negative emotions, such as shame and guilt, surrounding their weight and perceived health.

Stoicism

Stoicism is often understood in health literature as lacking emotional involvement and expression as well as exercising emotional control or endurance (Moore et al., 2012). Yong et al.'s (2001) foundational research on stoicism in healthcare experiences focused on older adults' pain responses. Many people relate behaviors such as "blocking out pain" and keeping a "stiff upper lip" with stoicism, which can result in suboptimal pain management due to under-reporting of symptoms and subsequent lack of treatment (Cagle & Bunting, 2017). Stoicism in health has been noted as a coping mechanism for dealing with stigma and negative healthcare experiences (Pathak et al., 2017; Latimer et al., 2014). In some scholarship, researchers have found that stoicism is prevalent amongst low-income individuals, resulting in a "self-reliance" effect that is used as a coping mechanism (Moore et al., 2012).

Pathak et al. (2017) aimed to illuminate the impact of stoicism as a system of self-regulation on health and found that some stoic patients had negative health outcomes, including avoiding or delaying seeking care for serious health problems. Pathak et al. (2017) also found that integrating the theory of stoic ideology in health research can help explain health seeking behaviors and improve communication. Moore et al. (2012) called for a distinctly sociological exploration of stoicism, stating that "stoicism has largely been overlooked in the sociology of health and illness" (p. 160). This article uses stoicism as a lens to interpret coping mechanisms displayed by the participants when facing stigmatizing experiences.

Materials and Methods

This study is part of a larger multi-sited ethnography designed to explore the lived experience among diverse, self-identified former or currently higher-weight (ever had a Body Mass Index ≥ 30) adults (≥18 years of age) (n=55) in an Atlantic Canadian province. Prior to data collection, this study received approval from the University of New Brunswick Research Ethics Board (#2019-035). There were five subgroups included in the study: higher-weight adults who were also i) older adults (Bombak et al., in press), ii) newcomers to Canada, iii) sexual and gender minorities (Bombak, Turner, et al., 2024), iv) Francophones, and v) low-income individuals. The study was designed to capture: i) the experiences of stigma among the subgroups of higher-weight individuals, ii) the recommendations for healthcare delivery and programming among these groups, and iii) the recommendations for improving access to healthcare delivery and health-promoting environments among these groups. This analysis reports specifically on data from the subgroup of participants living on an income below Statistics Canada's defini-

tion for "income adequacy" (low income) at the time of data collection. (See Table 1, used for recruitment.) The findings presented are drawn from a secondary thematic analysis performed by the first author on stigma coping as part of their graduate student thesis and, therefore, do not include all aspects of the ethnographic analysis.

Purposive sampling was used to recruit individuals using posters, social media, and print/radio advertising who met the weight and income criteria associated with the research study aim and objectives (Campbell et al. 2020). The study aimed to include ten low-income participants for two face-to-face, semi-structured interviews each at two- to three-month intervals with participant observation. In-depth interviewing techniques were used to combine both structure and flexibility (Legard, Keegan, & Ward, 2003). Following the tenets of both in-depth and semi-structured interviewing, the research team was reflexive and used prompts to tease out the meaningful, lived experiences of higher-weight individuals living on a low income. The use of in-depth, semi-structured interviews allowed participants the opportunity to speak about their most relevant lived experiences and present their own self-determined personal narratives about health and healthcare experiences. Intersectional interviewing techniques were also used.

The sampling strategy used allowed the study team to access intersecting lived experiences of participants. Researchers asked participants questions related to both weight stigma and income stigma separately, and researchers followed up with prompts and probes to address their experiences at these intersections (Campbell et al., 2020; Palinkas et al., 2015; Windsong, 2016).

The first interview focused on weight and low-income stigmas, and their intersections specifically relating to healthcare as a whole. The second interview addressed how places and spaces affect participants' overall wellbeing. During this phase of interviews, participants chose a place that they felt was relevant to their overall wellbeing. Observational data were collected that described the location selected by participants and their experiences at the location.

Field notes were taken during participant observation of both interviews as part of the larger ethnographic study. These field notes were not used as primary data during this sub-analysis; however, they provided important contextual information that was used to better understand the content of the interview. Field notes were vital in understanding the mood and intent from the participants that could not be captured in the transcriptions alone (Emerson, Fretz, & Shaw, 2011).

The two face-to-face interviews for each participant were audio-recorded and transcribed verbatim. The transcripts were indexed within the NVivo 12 computer software program. Using the NVivo 12 program encourages researcher reflexivity, dense coding, and organization of data, which makes it easier to identify emerging themes and concepts (Bringer, Johnston, & Brackenridge, 2006). The research team inductively developed initial codes through a process of evaluating and summarizing foundational critical weight and income stigma related literature (Weis & Willems, 2017). These initial codes were indexed in the NVivo software.

Table 1. Household income. Annual income recruitment table.

# People in Household	Annual Income
1 or 2	$14,999
3 or 4	$19,999
5 or more	$29,999

The transcripts were analyzed using thematic analysis and iterative thematic inquiry to identify recurring concepts and patterns within the data and contextualize them using theories of neoliberalism and intersectionality by one member of the research team (Morgan & Nica, 2020; LeCompte & Schensul, 2010; Ryan & Bernard, 2003). Primary data analysis was completed using thematic analysis, an inductive approach to data analysis that uses bottom-up searching to examine the transcripts and assess for larger, broad patterns and themes that are prominent in the data (Joy et al., 2023; LeCompte & Schensul, 2010). The research team engaged in a process of comparing, contrasting, and looking for similarities and differences within the data and between participants to seek out these patterns and themes.

After finding broad, emergent themes while doing primary analysis, a secondary analysis with a focus on identifying patterns related to neoliberalism and intersectionality was completed using iterative thematic inquiry (Morgan & Nica, 2020). Iterative thematic inquiry incorporates a more deductive approach to thematic coding and recognizes how previous knowledge about theory and social phenomena can be the basis of a rigorous data analysis (Morgan & Nica, 2020).

While generalizable conclusions are not normally pursued by qualitative researchers, rigorous data validation allows for increased accuracy of data interpretation by the research team (Weis & Willems, 2017) which we achieved through meticulous documentation and ongoing peer debriefing. When collecting the data, the research team met to discuss recurring patterns in the data and to ensure validity of the emergent themes; these meetings were informed by the diverse size, racial, gender and sexual, class, age, and national positionalities of the overall research team. These patterns were noted and added as codes in the NVivo 12 program to reflect the empirical interview data (Weis & Willems, 2017). As a graduate student, the first author met with their supervisor (the second author) throughout the project, as well, for additional debriefing about the findings. Documenting reflexive memos and an audit trail ensured rigor throughout data analysis (Creswell & Poth, 2007).

Results

During the course of the study, one participant did not complete a second interview, requiring recruitment of one additional participant. The final sample included 11 participants and a total of 21 interviews. The participants were predominantly women (n=8) with two men in the sample and one non-binary participant. Ten of the participants were White, one was Black, and there were no other self-identified racialized participants. The ages of the participants varied from 20-56 at the time of data collection.

Two major themes emerged from the data: 1) *uptake of stigmatizing, neoliberal health messaging* and 2) *coping with stigma*. *Coping with stigma* was further subdivided into *control over stigmatizing experiences* and *stoicism in the face of stigma*. Participants developed a sense of personal responsibility for their health and weight through exposure to neoliberal health messaging that became incorporated into their own worldview and ideals. Additionally, many participants were inclined to cope with both internalized and experienced stigma through the use of stoic behaviors. Participants often reframed their stigmatizing

experiences to present a version of themselves and their stories that are less vulnerable to stigma and that reduce negative assumptions about them or reject stigma altogether as they reproduced the dominant neoliberal understanding of health and weight and coped by differentiating themselves from other, more stigmatized bodies. The themes were similar across social locations such as gender, age, and racialization, and they are discussed below. Pseudonyms are used when discussing themes to protect participants' anonymity.

Uptake of stigmatizing neoliberal health messaging

The uptake of stigmatizing neoliberal health messaging refers to the process by which the participants incorporated weight stigma, income stigma, and neoliberal health messaging and ideals into their own worldview and subjectivity. In their interviews, participants reproduced neoliberal discourses that could lead to self-stigmatization and the idea that their wellbeing was a matter of personal responsibility, effectively rendering critiques of the healthcare system null. Participants constructed "solutions" to their weight and income that were within the realm of personal choice and behavioral changes.

Ryan, for example, expressed his perceptions of healthcare in the context of weight and the messaging he received from healthcare providers:

> Healthcare is about taking care of yourself, being in shape. Usually, when I think of healthcare. It's just keeping yourself a healthy weight is what most health professionals would encourage or weight loss.

Ryan saw weight loss as something that healthcare professionals should prescribe and encourage for their higher-weight patients. He appeared to have taken up the dominant, uncritical view of higher-weight and how it should be "treated." Later in the interview, Ryan indicated that accessibility supports for fat people, like bigger chairs, were "band-aid solutions" and that it was a "type of investment that doesn't pay back ever" implying that solutions targeting accessibility for higher-weight individuals do not positively impact the health of the population. Ryan's explicit reference to financial terms (i.e. "investment") highlights how focusing on cost reduction in healthcare continues to push neoliberal ideals within the system and prioritizes profit in healthcare situations.

Some participants described how healthcare providers placed individual responsibilities on their patients for losing weight in order to (presumably) improve health status. For instance, Elouise talked about how her doctor dismissed her healthcare concerns, since he liked to be "the boss" during their healthcare interactions:

> I think he [participant's doctor] likes to be the boss. My opinion is always less than his opinion, and, therefore, I should do whatever he says 'cause he's the boss.

Elouise's doctor diminished her agency as an active participant in her healthcare experience and provided stigmatizing care by asserting his dominance in "knowing best," thus drawing on traditional healthcare power-dynamics. While Elouise seemed skeptical about his assertion, she ultimately did not resist his power in the interaction and went on to explain that this behavior from her doctor made her hesitant to bring up future health problems. This also reinforced framings of low-income, higher-weight individuals as ignorant. Later in the interview, Elouise also discussed placing the burden of her health outcomes on herself because of the way her doctor had placed the blame on her.

Similarly, Jordan talked about this phenomenon during their interview:

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

How personal responsibility of health is mobilized in healthcare encounters is clear in Jordan's discussion of their healthcare experiences. Additionally, this quote highlights the taken-for-granted "common-sense" assumptions enforced through neoliberal health messaging that insinuate that fatness is a disease that individuals have the onus and ability to control. Jordan's critical understanding of the intersections between health and weight and their resistance to dominant neoliberal health messages contrasted with how other participants often reproduced these same messages in their interviews.

While Jordan complicated the taken-for-granted assumptions, Trevor took up these neoliberal health messages in his view on fatness and personal health responsibility:

> It's possible that when doctors are dealing with overweight people, like […] "Oh, my knees are killing me, my back is killing me," you know, "I'm in first stage diabetes" or when your diet is so horrendous…you're basically inviting diabetes. […] It's possible that the doctor will be like, "Well… there are things going on in your life. They're within your realm of control or, or at least they should be, or at least you should try to investigate the fact that they might be within your realm of responsibility to do something about."

In the quote above, Trevor endorsed the idea that health and weight are matters of personal responsibility. His response also showed, by invoking dietary explanations and linking, in a matter-of-fact way, necessary health complications to weight status, the widespread dominant ideas of higher-weight status as a simplistic, pathological, self-inflicted state of being.

In Ryan's interview, he also highlighted the ways in which weight and health become personal responsibility and that higher-weight patients can be seen as uncompliant when they do not lose weight:

> Another problem, too, I see a lot is people don't want the help. They just want to be unhealthy. Like they just don't care. So, I imagine that makes it difficult on the doctor, too. When, when you probably see so many people that are overweight and just don't want to change, and you tell them, "Hey, this is what's killing you," I can understand, well, someone's just like, "Hey, this is killing you. You don't care. Move on." If the patient doesn't care about themselves, it probably makes the doctor hard to care about, I imagine.

This quote showcases how Ryan has taken up neoliberal beliefs about weight loss and the implication that if higher-weight people do not lose weight that they do not care about themselves or their health and are non-compliant patients.

Further, Elouise exemplified the pressure of personal responsibility placed by providers on their patients regarding their food choices:

> Unless I didn't have the ability to buy fruits or vegetables and stuff, I don't think he would listen to that as an excuse or a reason or whatever. But, I don't think I'm treated any differently because I'm on disability or anything.

Elouise did not consider it stigmatizing when her doctor would not accept income barriers as an excuse for not being able to afford nutritious food. Elouise's statement suggests that her doctor saw health as something that is universally attainable and meant to be achieved on a personal level regardless of systemic barriers. Elouise appeared to excuse this behavior, likely because it was a more covert type of stigma and matches with neoliberal, classist health messaging.

Jordan also shared their perspectives on the struggle of seeking support as someone who lives on a low-income, is fat, or otherwise disadvantaged in healthcare provision:

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

Here, Jordan highlights the how neoliberal messaging about needing to be individually responsible for health and wellbeing has reduced the ability for many people to ask for help. The uptake and integration of neoliberalism into personal outlooks erodes the concept of community care and makes it more challenging for multiply disadvantaged people to ask for help. This may be especially true in healthcare interactions and is something that providers should consider when caring for higher-weight, low-income individuals.

Coping with stigma

There were numerous ways that the participants shared that they coped with stigma, including through exercising *control over stigmatizing experiences* and using *stoicism in the face of stigma* to minimize and/or reject the stigma they experienced.

Control over stigmatizing experiences

Participants appeared to have taken up the neoliberal ideology surrounding fatness and health; therefore, many participants sought to cope with stigma by adjusting their behaviors, attitudes, and negative emotions, such as shame and guilt, regarding their weight and perceived health. Control is described as the level the participants felt that they can regulate their emotions or experiences, compared to others. For many participants, controlling their attitude helped distance themselves from negative emotions related to stigma such as shame, guilt, and embarrassment. Of note, many participants avoided healthcare experiences and other stigmatizing places to control the stigma they felt.

Jordan shared how they cope with stigma by controlling how they engaged with healthcare professionals:

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

Jordan would engage in certain healthcare seeking behaviors, but sought to control their exposure to judgement and vulnerability and resultant negative self-perceptions.

Penelope also talked about how having negative experiences in healthcare can lead people to avoiding care altogether to protect themselves from shame and stigma:

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

Penelope brought up the important nuance of physical versus emotional pain. Many other participants talked about riding out pain and suffering at home rather than waiting for hours in an emergency room only to get stigmatizing and inadequate care. Judith, for instance, talked in her interview about avoiding care for her allergic reactions due to her past mistreatment by healthcare professionals:

> When I have reactions, I don't go. I just give myself the EpiPen and wait it out because it's low grade enough. Doctors wants me to go, but I won't go because of how I've been treated.

Judith has a chronic condition, which caused her to have low-grade allergic reactions often. While her doctors wanted her to go to the hospital to be treated, she avoided seeking care due to previous stigmatizing experiences. Instead, she kept a stiff upper lip in the face of pain and allergic reactions and labels these reactions as "low-grade enough," thus minimizing her healthcare needs and dealing with them herself.

Other participants would be more extreme in their avoidant behaviors as a way to control stigma and negative emotions. After a particularly negative healthcare experience, Angela developed intense healthcare avoidant behaviors, specifically for the emergency room (ER):

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

Here, Angela exemplified how far individuals go to avoid negative and stigmatizing experiences.

Other participants talked about their own healthcare

avoidant behaviors. For Ryan, this avoidance stemmed from dismissal by healthcare professionals.

> Negative experiences could be a barrier because that just makes you not want to go. If you know, hey, I have this problem and I'm just going to be told to go home, I probably won't go. I've done that a lot myself.

For several participants, the process of suffering through their pain was preferable to having stigmatizing experiences in healthcare, and, therefore, healthcare avoidant behaviors developed to control stigma in their lives. Avery, for example, claimed that her personality is an effective way of controlling stigma through her behaviors and reactions to other people dismissing her:

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

For Avery, this kind of control also impacts healthcare seeking behaviors – a crucial topic in considering the effects of stigma on health. Since Avery was able to vocalize her needs, she saw herself as someone who was able to access adequate care through her own self-advocacy in contrast to others who are not able to advocate for themselves and might have to access healthcare more frequently.

Participants found ways to control their situations and experiences to avoid stigma or judgement from others. Not all participants explicitly identified their behaviors as stigma management techniques, but many of their behaviors align with previous research on weight stigma and its effects. In many instances, stigma is directly correlated with negative health outcomes and avoidance of healthcare for extended periods of time.

Stoicism in the face of stigma

This theme refers to the process by which participants were stoic when experiencing stigma in healthcare through using behaviors like keeping a stiff upper lip and believing that there is no use in complaining about stigmatizing experiences or when describing the need for courage in the face of said experiences. Ryan talked about how keeping a "positive outlook" helped to shield him from negative experiences, effectively rejecting and dismissing the stigma he faced:

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

Ryan did not label experiences as stigmatizing as readily as other participants due to his ability to control his outlook and the comparisons he made to other higher-weight people. As a comparatively smaller higher-weight person, he had more privilege in his interactions with people. Additionally, he claimed a positive outlook changed his perception of what others might deem a negative experience.

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

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

Here, Angela minimized the stigma she faced as a way to reject the negative stereotypes associated with having a higher weight, yet still shared that she was seen as "different" in healthcare experiences.

In his interview, Trevor talked about the nuanced views that healthcare providers may hold regarding weight:

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

Trevor was able to discern stigmatizing attitudes that many people have, regardless of profession, about higher-weight individuals. However, there was still a willingness to give doctors the benefit of the doubt because of their education and understanding of other health conditions.

The idea that medical training is preventative of weight bias and stigma was pervasive among participants. Health professionals were often held as "knowing best" for their patients. This may have been a barrier to holding professionals accountable for their internal biases and may be why some people were hesitant about labelling people and experiences as stigmatizing or problematic.

Elizabeth was also hesitant about labelling experiences problematic and shared that she would "push herself" to her limits to avoid being seen as a lazy, higher-weight person while working alongside predominantly thin people:

> I don't want there to be reasons why I can't do things at the same level as everyone else. And I don't want to have to make excuses for myself just because of the size I am. Because I know that I can maintain my work level.

> It's just when you're being pushed to extremes, sometimes it feels like your limit is a lot lower than some other people.

Elizabeth went on in the interview to explain that she would push herself to the point of discomfort, but would attempt to keep her struggle invisible, a technique aligned with stoicism that was present among many participants.

Discussion

The experiences of higher-weight, low-income individuals in an Atlantic Canadian province can be understood through the themes of *uptake of stigma through neoliberal health messaging* and *stoicism in the face of stigma*. Overwhelmingly, the participants talked about their attitude in a way that follows neoliberal ideals.

For some participants, this appeared to lead to making excuses for stigma/stigmatizing experiences and feeling personally responsible for their health outcomes. However, participants, like Elouise, also reported feeling like their agency was diminished in healthcare experiences by doctors employing traditional power dynamics in their interactions that situate the doctor as "knowing best" due to the skills and technical knowledge that they hold (Odero et al., 2020). While these power dynamics have long been part of the doctor-patient relationship, the rise of accessible health information and social movements have increased the desire for patient autonomy and partnership with physicians in healthcare experiences (Kaba & Sooriakumaran, 2007; Odero et al., 2020; Szasz & Hollender, 1956). However, by reducing agency and autonomy through the enforcement of traditional power dynamics, physicians reify stereotypes that low-income, higher-weight individuals have decreased knowledge surrounding health and wellness (Farrell et al., 2016; Veatch, 2000). Most participants brought up the uptake of fatphobic discourses within their interviews. For some participants, the uptake was covert and may have been unconscious, while other participants were highly aware that they have been socialized to think in fatphobic ways. The uptake of fatphobic discourses was complex. Some participants were aware of how "obesity" discourses can be damaging; however, they seemed unaware they were reproducing fatphobic discourses in the way they spoke about their experiences and potential "solutions."

Higher-weight, low-income individuals who are multiply intersectionally-marginalized may be at a higher risk for internalizing fatphobic and classist beliefs. The way that these participants talked about weight and its causes made it clear that their understanding of weight is highly influenced by a neoliberal, stigmatizing perspective. This is unsurprising considering the neoliberal ideology that is dominant in healthcare messaging. The so-called "good citizen" is expected to take personal responsibility for their health behaviors and, therefore, stigmatize themselves under the dominant point of view (LeBesco, 2011). The uptake of neoliberal health messaging and ideals was pervasive in the data. There was a pattern among the responses of participants describing feeling personally responsible for their weight and income. Similarly, the participants' experiences living at a higher weight and a low income interacted to impact health outcomes, which was likely caused by the uptake of neoliberal health ideologies in which "the fat body is reframed as a drain on healthcare because fat people make bad personal consumption choices" (LeBesco, 2011, p. 155).

The subtle uptake of fatphobic discourses can help explain some participants' use of stigma management behaviors. Stigma coping mechanisms used by participants were influenced by the uptake of fatphobic discourses, which place the individual at the epicenter of responsibility for managing fatness and weight-based behaviors. Participants talked about the ability to control a situation or not getting themselves into a situation that would be stigmatizing. If participants found themselves in a situation that was potentially stigmatizing, they would often use stoic behaviors to control the outcome of the situation. When asked about their positive and negative experiences in healthcare and how they relate to their weight and income status, some participants were more likely to explicitly view their experiences as stigmatizing and label them as such. Others did not label their negative experiences as stigmatizing even when asked directly about them. For those who were hesitant or did not describe their experiences as stigmatizing, participants often appeared to justify structural or systemic issues. Participants often assumed personal blame or responsibility, insinuating that any negative experiences that they have had are due to who they are and not the negative biases that are instilled in others.

For some participants, the need to control stigma in healthcare experiences resulted in the use of stoic behaviors, which contribute to healthcare avoidance. This phenomenon is well documented in critical weight research and other research on weight stigma. Amy et al. (2006) report that many higher-weight women delayed or avoided seeking gynecological care due to disrespectful treatment and negative attitudes from providers relating to their weight, embarrassment about being weighed, and unsolicited advice about weight loss. Weight stigma is also related to negative mental and physical health implications due to internalized stigma and healthcare avoidant behaviors.

Avoidance of healthcare may be caused by stigmatizing experiences in a person's life, which, in turn, impacts their health-seeking behaviors (Gard & Wright, 2005; Mensinger et al., 2018). Internalized and/or experienced weight stigma affects future healthcare utilization among higher-weight individuals (Alberga et al., 2019; Amy et al., 2006; Ferrante et al., 2006; Mensinger, 2018; Mitchell et al., 2008; Pausé, 2014; Puhl & Heuer, 2009, 2010). Mensinger et al. (2018) demonstrated how internalized weight stigma was associated with body-related guilt and shame. Increased body-related guilt and shame manifested in increased healthcare stress which, in turn, was linked to an increase in healthcare avoidant behaviors. Further, LeBesco (2011) explains that an internalization of bodily shame, healthcare avoidant behaviors, and weight loss attempts can have "more deleterious health effects than a stable but high weight" (p. 160).

In their study assessing pain responses and stoicism in Indigenous children in Canada, Latimer et al. (2014) found that the feeling of distrust with doctors is a common predecessor for the development of stoic behaviors in healthcare experiences specifically. In the present study, when the participants did not avoid healthcare experiences altogether, they would often avoid talking about specific health issues that might be dismissed as weight related issues.

Adopting stoic ideals and behaviors leads to an evasion of necessary help from professional and personal support networks, often contributing to negative health consequences (Pathak et al., 2017). This type of behavior and healthcare avoidance can allow for medical problems to progress to the point of developing advanced forms of illness that otherwise could have been treated (Latimer et al., 2012). Other stoic coping behaviors, like

having a stiff upper lip or tolerating stigma in healthcare experiences, also precipitates misdiagnoses and miscommunications in healthcare visits.

Better education surrounding weight and class biases, including additional training resources for healthcare professionals and education on how to provide non-stigmatizing care, was one of the most prominent recommendations from participants for improving their healthcare experiences. Pausé (2014) details some recommendations on how to ensure non-stigmatizing practices are followed when providing care for fat patients stating that:

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

Pausé (2014) also explains how improving the physical spaces of healthcare environments can be more accessible and welcoming through the inclusion of fat-friendly furniture, gowns, and diagnostic machines/tools in addition to fat-friendly messaging in waiting rooms and in magazines. A comprehensive and multilevel approach is necessary to improve the resources and access to services for disadvantaged individuals in the province.

Strengths and limitations

One strength of the study is the fact that it was part of a larger research project with an overall diverse sample in terms of age, race/ethnicity, gender, sexuality language, and citizenship and a focus on intersectionality. However, while the larger study had significant diversity in the samples, each subsample, including the one used in this analysis, was less diverse. This subsample included predominantly women (n=8) and White people (n=10), reducing generalizability to diverse individuals. Future research needs to be conducted with larger samples that address stoicism as a coping mechanism for stigma specifically.

This research project used data collected for a larger ethnographic study with unique research aims. Due to this, there are some significant limitations of this analysis that must be acknowledged. The data collected focused on addressing research questions that were not specific to stigma management or stoicism in healthcare experiences. The small sample size for this subgroup analysis is also a limitation of the study.

While limitations were present, the researchers addressed them to the best of their abilities. The study team did achieve thematic saturation, suggesting that salient themes were identified. These themes emerged inductively and allowed for an innovative analytical focus. Furthermore, the repeated interviews and participant observation led to the gathering of rich, in-depth data and the ability to identify change over time.

Conclusions

In order to address the inequalities that low-income, higher-weight individuals face in healthcare and society in general, it is important to understand how they cope with these barriers. Due to the integration of neoliberal ideals in the healthcare system and public health messaging, participants often talked about their personal failings rather than the systemic disadvantaging of higher-weight, low-income individuals in society. Using stigma management behaviors to cope with systemic barriers allowed participants to try to distance themselves from the negative emotions associated with the personal failings that neoliberalist health messaging can provoke. This pattern was compounded by the beliefs surrounding personal responsibility for income and class, invoking the idea that low-income individuals should perform in a way that distances themselves from the negative stereotypes associated with low socioeconomic status. Often, this led participants to self-stigmatize through integrating neoliberal and fatphobic ideals into their own sense of self, negatively impacting how they viewed both their body and their health, proving how pervasive these discourses are. Some participants held the beliefs that weight could and should be controlled through personal responsibility, including maintaining strict diet and exercise regimens, and held themselves to unattainable standards that are reinforced through public health messaging.

The uptake of neoliberal ideals and fatphobic discourses of needing to lose weight to be a moral member of society clearly has major implications on the coping mechanisms of the participants. These implications manifest in negative mental and physical health outcomes and must be addressed in order to best care for higher-weight and low-income individuals (Harwood et al., 2022). As income is a widely understood social determinant of health, implementing income support programs like a universal basic income could potentially diminish stigmatizing attitudes and improve health overall (Ruckert et al., 2018). Healthcare providers often employ a "weight-centric approach" with an emphasis on an individual's body weight as a condition to be treated, leading to a lack of diagnosis or misdiagnosis of the true condition that an individual is seeking care for (Tylka et al., 2014). To address this, providers could consider employing a weight-inclusive approach to support the health of all people and minimize stigmatizing experiences faced by patients by looking beyond weight to understand the other factors that impact an individual's health (Tylka et al., 2014). Finally, education is cited as the first step in stigma reduction and is often most effective when combined with other strategies (Heijnders & Van Der Meij, 2006). While more systemic and structural changes are essential, it is important to also provide stigma education, especially to healthcare providers, to address the unfair and stereotypical beliefs that many people hold and perpetuate.

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