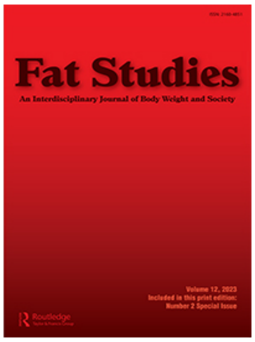

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"It has literally been a lifesaver": the role of "knowing kinship" in supporting fat women to navigate medical fatphobia

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ABSTRACT
This article focuses on the development of online fat kinship in the Health at Every Size (HAES) movement. Drawing upon 15 fat women's experiences of their HAES community membership, we explore the ways that fat kinship develops around fatphobic experiences, and how it can facilitate the mitigation of fat oppression. Building upon the notion of the "knowing community," we suggest that sharing experiences of, and developing tactics against, medical fatphobia transforms "knowing communities" into "knowing kinships.," characterized by mutual support and affective relationships. We argue that sharing experiences on egalitarian social networking platforms builds a supportive, safe, and affective kinship network of "knowing" members. Through this online-based kinship network, fat women not only share stories of medical fatphobia but also collaboratively develop tactics of "everyday resistance" against it, including the identification of fat positive healthcare practitioners and the honing of communication strategies to optimize healthcare interactions. These tactics, we suggest, are developed to convey a high degree of "cultural health capital" which undermines assumptions of fat patients as apathetic leaving less space for fatphobic treatment. Although we focus on kinship development in the HAES landscape, we conclude with some reflections on the application of our "knowing kinship" framework to other fat populations.

KEYWORDS
Cultural health capital; knowing kinship; medical fatphobia; weight stigma; health at every size

Introduction

This article focuses on the development of online fat kinship in the Health at Every Size (HAES) movement, which rejects weight as a proxy for health and advocates for fair and respectful healthcare treatment of fat individuals (Bacon 2010). We build upon the frameworks of cultural health capital (Shim 2010) and the "knowing community" (Davenport et al. 2018) to explore how fat kinship is produced online through sharing experiences and advice on mitigating medical fatphobia. We conceptualize this medical oppression of fat people as stemming from perceived low cultural health capital.

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The HAES movement is a sub-community within what has been called the "fatosphere" – a digital, fat positive space which provides "possibilities for participating in the collectivization and politicization" of fatness (Charmaz and Rosenfeld 2010, 322). Such digital "safe spaces" of radical fat acceptance and activism are important resources for fat people to "resist the more culturally available, and therefore more powerful perspectives" of fat bodies which in global northern societies (Casadó-Marín and Gracia-Arnaiz 2020; Davenport et al. 2018).

One of the key tenets of HAES is its opposition of biomedical pathologization of fatness which frames fat individuals as inherently problematic, lacking self-control, and apathetic toward health (Bacon 2010). Such tropes often manifest as "medical fatphobia," which equates fatness with ill health and deems fat bodies "unworthy of medical time" (Ananthakumar et al. 2020, 1). Medical fatphobia upholds an "aesthetic of health" (Gronning, Scambler, and Tjora 2013, 266) where weight is understood as a proxy for health and fat individuals are excluded from definitions of "healthiness." This over-attribution of illness to fatness results in fat patients receiving worse quality healthcare (Ananthakumar et al. 2020; Russell and Carryer 2013). Anderson et al. (2001) argue that medical fatphobia is more pronounced in women, for whom fatness is understood as a transgression of health expectations *and* non-adherence to culturally-mediated, thin-centric beauty ideals. These beauty ideals, according to Hesse-Biber (2008), permeate all aspects of contemporary global northern societies and create a "cult" around thin female bodies. Consequently, she argues, all women are under multiple pressures (social, political, economic, health) to dedicate significant time and energy to pursuing the thin ideal. For Gailey (2014), the deep entrenchment of this thin ideal places fat women in a paradoxical position as both *hyper*-visible and *in*visible because of their transgressive bodies. She argues that the neo-liberal focus on health as a moral obligation "perpetuates the hyper(in)visibility of fat women" (Gailey 2014, 83).

We use Shim's (2010) concept of cultural health capital to understand the poorer quality healthcare experienced by fat individuals. Inspired by Bourdieu's (1977) notion of "cultural capital," which maintains that particular cultural practices are forms of capital through which individuals can accumulate status and power, Shim claims that cultural health capital shapes individuals' ability to effectively navigate healthcare systems, including communication with practitioners and self-presentation as a "good patient." Cultural health capital embodies a collection of skills and attributes that enable patients to "optimize their relationships with health professionals and the care they receive," leading to better healthcare outcomes (Shim 2010, 3). Many off these attributes conflict with culturally-mediated messages about fatness, including self-discipline/control and proactive attitudes toward health (Shim 2010). Resultantly, fat patients are assumed to have low cultural health capital, are excluded from joint decision-making, and generally suffer worse healthcare outcomes (Ananthakumar et al. 2020; Aramburu Algeria Drury and Louis 2002).

This assumption of low cultural health capital has a tangible impact on fat patients' physical and mental health. Fatphobic medical encounters cause considerable stress (Gronning, Scambler, and Tjora 2013; Sutin, Stephan, and Antonio Terracciano 2015), and fat patients are often given generic advice focused solely on weight-loss and even encouraged into disordered eating and exercise habits (Aldrick and Hackley 2010; Bordo 1990; Russell and Carryer 2013). Moreover, the reading of fat bodies as antithetical to prudent health often results in withholding procedures, including cancer screening (Ananthakumar et al. 2020) and postponement of vital surgeries (Cohen et al. 2008; Phelan et al. 2015).

Against this backdrop of medical fatphobia and assumed low cultural health capital, fat positive online communities become sites of support. The fatosphere provides space where predominant, pathologizing biomedical tropes questioned and countered. The strong critique of biomedical discourses in fat positive online spaces is produced and legitimated through alternative forms of expertise, notably the lived experience of inhabiting a fat body. These lived experience spaces create what Davenport et al. (2018) call a "knowing community" where members are positioned as "experts by experience" that occupy a "privileged source of insight not available to professionals" (283). This collaborative "knowing community," is hinged on shared values antithetical to biomedical constructions of health and fatness. Through the creation of this collaborative community, individuals with simplistic, stigmatizing and non-experiential perspectives are positioned as an "out-group" whose claims about fat are discursively discredited. Policy-makers, mainstream media, and healthcare practitioners are generally found in this "out-group" as a result of their reliance upon traditional, fatphobic and often disputed biomedical knowledge that often contradicts fat individuals' embodied experiences and the tenets of HAES.

In this article we extend the "knowing community" concept as it applies to the fatosphere by introducing the notion of "knowing kinship." Davenport et al. (2018) researched how fat positive blog writers discursively create a sense of community using terms like "us" and "our community." Yet, blogs exist as a relatively one-way exchange, with a somewhat invisible readership and a privileged mode of "knowing" (the author's). We suggest that more egalitarian exchanges on social media platforms create not just a "knowing community," but a genuine sense of kinship through the exchange of traumatic medical experiences and resistance tactics. We term this a "knowing kinship," where *knowing* arises from lived experiences of fat stigma (echoing Davenport et al.), but *kinship* stems from the equal exchange of these experiences and the co-production of resistance which works to shape group members' cultural health capital and ensure fair biomedical treatment.

In what follows, we outline our methodological approach before exploring fat kinship in relation to medical fatphobia. We conclude with discussion of future research directions.

Methods

Study site

This article is based on interviews with 15 women who were recruited from a private HAES Facebook group. This group is a hub of fat positive, health-focused information, and space to share everyday experiences of inhabiting the world in a fat body. The group was identified for recruitment because its HAES focus aligned with our research questions about support for medical fatphobia. Although there are several HAES social media groups, our recruitment site is one of the largest, busiest, and most diverse groups in the HAES landscape. At the time of research, the group had around 6,500 members across a range of countries and a variety of socioeconomic, ethnic, and age backgrounds.

Using a purposive sampling approach, we recruited 15 female group members for semi-structured interviews. We undertook interviews rather than gathering naturalized data from the group page itself because we sought to understand members' *experiences* of fat kinship and its role in navigating medical fatphobia, which would not have been possible to ascertain through online data alone.

Data collection and analysis

We utilized a purposive sampling approach to recruit women who self-identified as "fat," lived in either Australia, Canada, the UK, or the U.S., were 25–45 years old, and described themselves as having "middle" or "upper" socioeconomic class backgrounds. We restricted our sample to these locations as contexts where fatness is understood as a deviant. While there are some differences between these healthcare systems, we recruited participants based on their shared experience of medical fatphobia, which is ubiquitous across Western healthcare systems. The latter demographic criteria were established to control for further factors compounding a given patients' experiences in healthcare systems, such as structural classism, racism, or ageism (Crenshaw 1991; O'Campo and Burke 2004). Our research focused on women only because women are more likely to be stigmatized for being fat (Bordo 1990) and are more likely to experience medical fatphobia (Anderson et al. 2001).

To recruit participants, CK published a post in the Facebook group in October 2019, outlining the research objective and inviting members to contact her if they wished to participate in the project. Upon contacting CK, participants received a participant information sheet and consent form, and a mutually convenient interview time was arranged. As per the British Sociological Association's (2017) ethical guidelines, participants were afforded full anonymity and confidentiality, data was handled securely, and participants gave fully informed consent which they could withdraw at any point. Our final sample of 15 women comprised two Canadian, ten US, and three British participants. Participants were aged 27 to 44 years, with a mean age of 35. While participants were sampled from one specific HAES Facebook group, many of them were part of other online-based fat kinship networks. Our scope of analysis thus goes beyond the specific HAES group.

Interviews took place via online platforms between October 2019 and January 2020. They lasted 30–60 minutes, were audio-recorded, and later transcribed. Interviews were structured by a topic guide exploring how fatness impacted participants' experiences of healthcare encounters, and how they used fat positive online kinships to negotiate these medical encounters. The semi-structured nature of interviews ensured that participants had sufficient room to freely share their experiences (Bechhofer and Paterson 2000), while the topic guide gave sufficient consistency and comparability between interviews (Fylan 2005).

Data analysis followed an abductive approach, which was informed by our existing theoretical positions yet allowed the space for new theoretical reasoning (Tavory and Timmermans 2014). Inasmuch, we were inductively guided by our participants' data but used the theoretical frameworks of medical fatphobia and Davenport et al.'s (2018) notion the "knowing community" as sensitizing tools. Our data analysis followed three broad stages. Firstly, we coded the data inductively to allow participants' pertinent reflections and experiences to emerge. Secondly, we organized these codes into broader themes reflecting that sharing experiences acted as a powerful tool of kinship production through which modes of resistance were co-produced. Finally, we situated our thematic schema within the frameworks of medical fatphobia and fat kinship communities to answer the research question.

Results

From "knowing communities" to "knowing kinships"

All participants reported drawing on online fat communities to help them negotiate healthcare settings, their outcomes, and effects. Like Mariah, many participants described fat kinships as a crucial tool to reduce anxiety around medical encounters:

> If feel [fat kinship] reduces my anxiety to a point, [. . .] when I have to go to the doctor's knowing that if I have issues, I can go [to the group].

Participants described discovering fat positive online communities after struggling with body image, and weight stigma, often for a long time. They most frequently recounted having found fat positivity by chance and then actively searching for more information on the topic. Only a minority of participants had arrived in the “fatosphere” after a personal recommendation. Similar to Margavio Striley and Hutchens (2020) participants, the women we interviewed were motivated to join fat positive communities for both personal and systemic reasons. Participants’ personal motivations, centered on gaining advice and support for individual problems, were located within a wider, system-oriented landscape of fat activism rooted in questioning biomedical understandings of fat bodies. Layla explained as follows:

> It makes me feel more encouraged to do these things, and to make changes, and to get better at asking for support. Because I know it’s not just me, it’s not only my problem.

Engagement with these digital communities was not unidirectional, where participants simply took advice from fat communities. Instead, participants described actively contributing to community-building through sharing experiences and engaging in conversations often involving multiple community members at once. This community-building took various forms, including commenting on other people’s posts, creating new posts to share personal perspectives, providing links to external content like newspaper articles, or simply “liking” useful posts.

Through these interactions and conversations, participants described a sense of commonality. They felt understood through a shared “knowing” – e.g. knowing everyday life as a fat person, knowing stigmatization, and specifically knowing medical fatphobia. This sense of “knowing,” echoing Davenport et al.’s (2018) findings, stemmed from lived experiences of structural and everyday discrimination. Yet unlike the discursive processes of community building undertaken by Davenport et al.’s bloggers, where the audience is only assumed, participants reported that this sense of “knowing” united the community through mutual story sharing. For many participants, opening up about experiences of stigma was facilitated by other group members being likely to “know” these experiences too. Tamsyn, for example, described sharing her struggles with weight stigma, and feeling understood and reassured by the resonances with other group members:

> I’ve definitely shared some of my struggles and have had positive experiences in the group. It helps to have people who relate, and who understand, and have been through similar things. Sometimes when I’m having a hard time, I’ll post. I’ve only posted a couple of times, but it’s always helpful when I do.

Linda further elaborated on these shared experiences and the connectivity they give rise to:

> We all have some commonality, kind of, woven into our experiences. And so it's been really empowering to find other people, and not just feel like the lonely fat outcast that's the only one of my friends who's fat. And so it's been really validating.

For both Tamsyn and Linda, the shared knowing of fat-bodied experiences connected them to the Facebook group community in an affective way. Indira, though, went even further, talking about the Facebook group as the *only* kinship space where she could discuss fat-related issues because other spaces, kinships, and relationships in her life were characterized by a lack of knowing, reflecting what Davenport et al. (2018) call the "out-group":

> It is oftentimes the only community I have to talk about [weight-related] things because the people around me [. . .] don't know anything about fat positive things [. . .]. And I don't have the energy to educate everyone around me. [laughs]

She continued to explain the extent of this affective connection with regards to her mental health and body acceptance:

> I think before I found [HAES Facebook group] and intuitive eating and these online communities, I was at a point where, well, to be honest, I was really suicidal. Because I was experiencing that diets don't work, but I also didn't know what else to do to get the love and acceptance back that I didn't have anymore because my body had changed. And then finding a community that says, hey, you don't have to do that. You're fine and we accept you. This has turned everything around. It has literally been a lifesaver.

By sharing their experiences and engaging with others' stories, members of the group both display their vulnerabilities and support others with navigating their struggles. Inasmuch, the "knowing community," united by the shared experiences of being fat and suffering medical fatphobia, transforms into a "knowing *kinship*" characterized by mutually supportive relationships which are facilitated by social media platforms, and allow conversations and dialogue. Christal, for example, described these kinship networks as safe spaces of empathy and compassion, and a refuge from fatphobic abuse:

> [Fat positive online communities] give me somewhere safe and not scary, where I could report something if I'm just looking for empathy or advice or a suggestion, and not have to fear, like, shitty responses.

Through this knowing kinship, participants shared stories of medical fatphobia and assumptions of low cultural health capital and also collaboratively developed tactics of "everyday resistance" against it. These tactics were developed through members' experiences of discrimination in healthcare contexts and through the adaptation and modification of members' tips for navigating this discrimination. In other words, unlike in blogs, one poster's tactics were not privileged as a "rule" for others to follow but were instead added to and adapted over time through other members' comments and suggestions. Two specific tactics were highlighted by participants as being developed through kinship ties and mutual support. These tactics are (i) identifying supportive, non-fatphobic healthcare practitioners, and (ii) positioning the fat body and developing effective communication strategies to optimize healthcare encounters. We take each of these tactics in turn, describing the ways they were reported as both useful for mitigating medical fatphobia and important to kinship development.

Tactics of everyday resistance

Identifying supportive practitioners

A key function of fat kinships was supplying participants with information about "safe" practitioners that group members had had positive, non-fatphobic experiences with, as Lucy highlighted:

> I had found a recommendation for [my doctor] in a Facebook group online that made me think she would be fine with working with fat patients.

By "fine with working with fat patients," Lucy talked specifically about practices which do not treat fat people differently from thin patients, or disproportionately focus on weight as the locus of health problems. Identifying supportive healthcare practitioners was both a personal and collective act of everyday resistance against medical fatphobia. By engaging with supportive practitioners, participants hoped to avoid traumatic medical encounters while also undermining the broader structure of stigma within which medical fatphobia flourishes.

Kinship was developed through sharing supportive practitioners' details as an act of care toward other group members. While these acts of care were performed digitally, they also located kinship within physical spaces as recommendations would be sought and given based on locality. Lena talked about how digital kinship moved into the offline world through these recommendations:

> Through sharing experience, I know it's not just me. So I'm part of a big community online, and also through that I have some people that I met in real life.

Through these recommendations, the boundaries of the knowing kinship became somewhat fluid, and supportive practitioners were brought, albeit unwittingly and symbolically, into the "in-group" of the kinship. In other words, while Davenport et al. (2018) locate healthcare practitioners as part of the "out-group" of actors who rely on over-simplified, biomedical tropes of fatness, our participants suggested a more nuanced delineation between "in-group" (kinship members) and "out-group" (nonmembers).

Positioning and communicating in healthcare settings

A second key tactic of resistance that was developed through participants' knowing kinship was how to physically position fat bodies and effectively communicate in healthcare spaces. To navigate the contested nature of their embodiment in medical spaces, participants took inspiration from group members' advice about positioning the fat body. The aim of such positioning was to minimize stigma and increase the performance of high cultural health capital. Lydia, for instance, described adopting a way of positioning her body that she had heard about in the group:

> The trick about facing away from the scale and asking not to hear the number. That was something that someone in a group mentioned they did at the doctors. And I was, like, that's a great idea! And so it's these pulls and tricks and resources and a community of support to come back to when I have questions or I'm frustrated.

Through physically maneuvering their bodies in particular ways, participants were able to occupy space in ways that non-verbally communicated confidence and undermined assumptions about their low cultural health capital. These corporeal communication tactics were also combined with verbal strategies which were developed through fat kinships and mostly centered on self-advocacy and forthright communications, leaving less space for medical fatphobia. As a result of being a member of several fat positive Facebook groups, Lydia, for instance, explained how she changed her communication style with healthcare practitioners:

> I definitely feel like I advocate for myself a lot more [since I started being part of fat positive online communities].

Rachael specifically described developing a two-stage verbal strategy of sharing, firstly, why she had visited the doctors and, secondly, what she expected to be done:

> This is a problem and I want you to look into it.

Several participants described seeing the specific tactic of threating to leave a doctor's office being shared within fat kinship networks and subsequently adopting this approach to optimize their healthcare interactions. Though potentially complicated by wider financial implications in privatized healthcare systems, threatening to leave served as both a verbal and non-verbal signal that participants were intolerant of medical fatphobic behaviors, as Clara described:

> I talked to [healthcare providers] early on and was, like, do you vibe with this kind of [fat positive] philosophy? And if they were like, yes, then I was cool! And if they said, but what about this, I said it doesn't matter because I don't see people who don't.

This tactic of developing physical positioning and communication strategies aims to convey a high degree of cultural health capital, thereby undermining biomedical assumptions of fat patients as apathetic. As Shim (2010) argues, advocating for oneself is a key marker of high cultural health capital and can replace medical paternalism with share decision making (Dubbin, Suki Chang, and Shim 2013). Therefore, by displaying a high degree of self-advocacy, participants were able to adapt their behaviors within healthcare encounters to mirror those expected of patients with high cultural health capital.

Yet participants did not just follow advice from the group about communication and instead used it as a starting point for developing personal techniques adapted to their unique situations. Penelope, for example, described identifying specific language used by group members to communicate with practitioners, then using it in her own encounters:

> [Fat positive online communities] have also given me ideas for communication. The ways I've seen some members of groups explain how they talk to their medical team has given me some ideas for language I could adopt.

In turn, these personal adaptations would often be shared with the fat kinship group, co-developing a cache of communication-based resistance tactics. This sharing also strengthened the sense of a knowing kinship through a demonstration of both knowing how to physically and verbally mitigate medical fatphobia, and of developing genuine care toward other members.

Discussion

In this article, we have introduced the notion of a "knowing kinship" as a framework to understand community-building and mutual support in the HAES online landscape. Building upon Davenport et al.'s (2018) notion of a "knowing community," we have argued that knowing kinship develops in the HAES area of the "fatosphere" around the sharing of common experiences of medical fatphobia and the co-production of tactics to resist fatphobic stigmatization. We have explored the identification of fat positive practitioners, and verbal and non-verbal communication devices which function as modes of everyday resistance and undermine assumptions that fat individuals will have low cultural health capital characterized by apathy and a lack of self-discipline (Shim 2010).

While we present a fairly positive narrative of kinship in the HAES movement, it is important to highlight that there are limits to the extent of fat patients' resistance. In particular, the deep entrenchment of a "weight centred health paradigm" (Bacon 2010) in healthcare and the inherent power asymmetry in doctor/patient interactions (Pilnick and Dingwall 2011) may constrain fat patients' efforts to reorient healthcare encounters and resist dominant fatphobic biomedical tropes. The success of resistance tactics like those our participants described is somewhat reliant on healthcare practitioners being receptive of patients' input and willing to have their ingrained prejudices challenged. Yet research consistently demonstrates that higher social value is attributed to biomedical knowledge compared to patients' embodied, experiential perspectives. This reproduces medical power and limits the possibility for patients to counter medical advice or judgment (Lupton 1995). Moreover, fat patients impacted by other inequalities such as their ethnicity or socio-economic background are likely to find it even more challenging to resist dominant medical constructions of fat bodies. In contexts such as the U.S. where healthcare is not free at the point of access, the potential for specific resistance techniques such as leaving a doctor's office is severely constrained by the financial implications for fat individuals. Inasmuch, although research indicates that weight-centered health pressures are most pronounced in white, middle-class women, this positionality also entails considerable status privilege through which to negotiate their cultural health capital (Blacksher 2008; Madden 2015; Stepanikova and Oates 2018). In this vein, our research is limited in its homogenous and limited sample. While we deliberately sampled white participants from more affluent backgrounds to understand medical fatphobia uncomplicated by intersecting inequalities, this means our research does not capture the diverse experiences of kinship for marginalized women.

Additionally, our sample was recruited from a Facebook group with a distinct ideological underpinning around medical fatphobia, meaning our participants had preexisting knowledge and opinions of the phenomenon. While on the one hand this enabled us to focus specifically on kinship development around this issue, on the other hand, our findings are based on responses from a well-informed group who are politically using fat positive kinships to navigate medical fatphobia. To mitigate these biases to the best of our abilities, we did not assume any degree of prior knowledge and used neutral lines of questioning during interviews, providing participants with freedom to share their unfiltered experiences within healthcare systems and within fat kinship networks. Ultimately, our research benefitted from participants' prior engagement with the concepts examined in this research because participants demonstrated a high degree of reflexivity, critical engagement, and deep insight into the workings of fat kinship. Future research would nonetheless benefit from understanding what medically-focused fat kinship means for people who are not actively participating in the HAES world.

Notwithstanding these limitations, the paucity of research into negotiations of medical fatphobia means our research makes a valuable contribution to extant academic and practice discourse. In particular, the notion of "knowing kinship" offers considerable potential for exploring other communities and kinships in, and outside of, the "fatosphere." In the first instance, our participants demonstrated that equitable health and a deep yearning for social justice was at the heart of many fat women's lives, which might be more readily mobilized around specific women's health issues, including pregnancy or menopause. Moreover, while our notion of the "knowing kinship" applies especially to the role that kinship plays in HAES activism, our contributions may apply to other fat positive communities such as queer fat activism (Pausé, Wykes, and Murray 2014) or those specifically focused on ethnic minority experiences (Johansson 2020). In these instances, "knowing" arises not just from a shared experience of fatness but other intersectional experiences – e.g. being fat *and* menopausal, being fat *and* Black. Inasmuch, the notion of a "knowing kinship" can be used to make sense of the ways intersectional factors structure experiences of stigma and how kinships develop around their resistance.

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No potential conflict of interest was reported by the author(s).

Notes on contributors

Carolin Kost is a sociologist and medical anthropologist with a research interest in fat individuals' lived experiences, particularly as they relate to healthcare settings.

Kimberly Jamie is an Associate Professor of Sociology. She teaches and researches health and medicine in everyday life, the work of healthcare practitioners, and the sociology of the body with a particular focus on women's bodies. Her work has been published in leading academic journals as well as shared across media platforms on TV, radio, and podcasts.

Data availability statement

Data are available from the corresponding author on request.

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