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Working toward eradicating weight stigma by combating pathologization: A qualitative pilot study using direct contact and narrative medicine

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Abstract

Stigma against fat people permeates every level of healthcare, yet most attempts to reduce weight stigma among healthcare providers have shown only marginal results. Fat studies, a field that rigorously interrogates negative assumptions about fatness, can help social psychologists understand weight stigma by centering the pathologization of fatness as a major contributor to weight stigma at the structural and interpersonal level. A fat studies approach also reorients the normative goal of weight stigma interventions from reducing stigma to eradicating stigma and calls for methods that reject weight stigma's roots in medicine and medical discourse. Even nuanced and sympathetic models of "obesity" cannot combat stigma that is structurally based in medical authority. We applied these principles to develop a new method of weight stigma intervention: direct contact structured through narrative medicine. In a qualitative pilot study, four medical students and two fat activist community members met for five 2-hours narrative medicine workshops over 5 weeks. All participants completed focus group interviews about the experience. Interview transcript analysis revealed that these workshops provided a space for depathologizing, humanizing, empathy-inducing, and power-leveling interactions between medical students and fat people, where members of both groups reported benefiting from the experience. We conclude that non-pathologizing approaches to eradicating weight stigma are not only feasible, but both ethically and methodologically necessary.

1 | INTRODUCTION

Despite an extensive body of research showing the negative consequences of weight stigma, healthcare providers (HCPs) continue to marginalize fat¹ patients through negative attitudes, stereotypical beliefs, and discriminatory actions (Dánielsdóttir et al., 2010; Phelan et al., 2015). Weight stigma is present through all stages of medical training, where derogatory comments about fat patients abound

¹We use the term "fat" as a neutral descriptor of size that is consistent with the field of fat studies (Meadows & Dánielsdóttir, 2016; Rothblum & Solovay, 2009).

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(see Flint, 2015). It is therefore imperative to combat weight stigma early in medical education. Reviews of weight stigma reduction research have shown that existing interventions are ineffective, or, at best, only minimally effective (Alberga et al., 2016; Lee et al., 2014). There is a clear need for new approaches in this field. Fat studies is an interdisciplinary field of scholarship that may offer new insights for intervening in weight stigma, guided by three tenets: first, the oppression of fat people exists on a structural level; second, fat bodies are part of the natural diversity of body sizes; and third, any knowledge produced about fat people should include fat people (Cooper, 2016; Manokaran et al., 2020; Pausé, 2020; Rothblum & Solovay, 2009). In the present study, we draw from the field of fat

studies to a) construct a new theoretical framework for understanding weight stigma centered around the concept of pathologization, b) develop a new normative framework centered around the goal of eradicating weight stigma, and c) design and qualitatively assess an alternative weight stigma intervention that uses direct contact structured by narrative medicine.

1.1 | Defining stigma

To bridge the gap between the structural approach of fat studies and the interpersonal approach of social psychology, we draw on Link and Phelan's (2001) multifaceted definition of stigma. According to Link and Phelan, stigma exists "when elements of labeling, stereotyping, separating, status loss, and discrimination co-occur in a power situation that allows these processes to unfold" (2001, p. 382). Certain forms of human variation are selected and deemed salient (labeling). These labeled differences are linked to a set of undesirable characteristics (stereotyping). People subject to this stereotyped label become a homogenized, negative outgroup that is seen as fundamentally different from the ingroup (separating). As a result, members of the outgroup are devalued, rejected, and excluded from many realms of life; they experience a "general downward placement" in status hierarchies and face internalized, interpersonal, and structural discrimination (Link & Phelan, 2001, p. 371). Every step of this process relies on the relative distribution of social, economic, and political power.

1.2 | Pathologization and weight stigma

One source of power that shapes the form of stigma is medical authority: medicine and medical discourses have the ability to define people as deviant. For decades, researchers interested in weight stigma have documented the ways that categories created and sanctioned by these discourses contribute to stigma. Consider this passage from a 1975 article:

The chronically fat person's weight problem often becomes a central fact of his existence and limits the choice of social roles and attitudes open to him ... Obesity's negative value in our society seems to be connected with its being viewed as an unhealthy condition in a society that places great value on health and as a product of the failure to control one's impulses in a society that values self-denial. Therefore, obesity becomes a sign of disease and immorality. The obese person is stigmatized. (Flack & Grayer, 1975, p. 484)

In this quote, the authors explain how a medical diagnosis (turning fatness into the "disease" of "obesity") can become the most important thing about a fat person, reducing their humanity to bodily

deviance and creating stigma. Yet the social psychological literature on weight stigma (and stigma more broadly) has no theory through which to understand this influence. In their highly cited review on the origins of weight stigma, Puhl and Brownell (2003) invoke attribution theory, realistic conflict theory, social identity theory, integrated threat theory, and evolutionary theories, but make no mention of the role that medical discourses play in generating and legitimizing stigma against fat people (see also Diedrichs & Puhl, 2016). To fill this gap in the literature, we use the concept of pathologization to describe the particular kind of stigma that emerges from the institutional power of medicine.

Drawing on Link and Phelan's stigma framework, we define pathologization as a particular form of stigma rooted in medical authority that has three components: diagnosing, dehumanizing, and intervening.² A substantial body of research in health psychology has shown that laypeople possess commonsense illness representations built out of medical information from media, HCPs, public health campaigns, etc., as well as from personal experience (for a review, see Benyamini, 2011). The cognitive content of these illness representations generally includes: a diagnostic label, its associated symptoms, its consequences, its course/prognosis, its cause, and its cure or treatment (Hagger & Orbell, 2003; Lau & Hartman, 1983). More recently, researchers have studied these representations as "illness schemas" that can be activated (Lowe & Norman, 2017; Orbell et al., 2015), shaping information processing (Henderson et al., 2007), and behavior (Orbell & Henderson, 2016). We posit that when a perceiver views a member of a pathologized group and identifies that person with that label, the perceiver's illness schema is activated, which then guides the perceiver's inferences about that person. For example, when a perceiver sees a fat woman and classifies her as "obese," they might assume she is "obese" due to living in a food desert and not having access to fresh vegetables; they might also assume that this woman's size means she has diabetes and an inevitably shortened life span. Thus, while stigma broadly involves labeling and stereotyping, pathologization specifically involves *diagnosing*, a concept that refers both to the social classification of an individual into an illness schema and the use of that illness schema to make inferences about members of a pathologized group. In other words, pathologization involves embedding a clinical way of thinking into everyday social cognition, such that most people become trained to view members of a pathologized group as patients in need of treatment.

In pathologization, we hypothesize that illness schemas override usual processes of person perception; pathologized group members become viewed as a disease first, and a person second. Thus, the second component of pathologization is *dehumanizing*, in which members of a pathologized group are defined by and reduced to their medical label and the associated illness schema. Theoretical

²Here we focus on the first two components, diagnosing, and dehumanizing, which are more relevant to the present study. While the broader concept of stigma involves groups that are lowered in status, rejected, and/or excluded, the equivalent component of pathologization is *intervening*. That is, pathologized groups are subject to interventions of treatment and prevention designed to undo, eliminate, or preempt their ways of being.

models of dehumanization refer to a wide variety of human attributes that are denied through dehumanization, including competence, agency, individuality, rationality, self-control, moral responsibility, warmth, trustworthiness, and the capacity to suffer and be harmed (Fiske, 2018; Haslam, 2006; Waytz et al., 2010). We posit that when a perceiver views a person as a member of a pathologized group, the aspects of the person that become salient are those that relate to the illness schema—for example, the causes of their disease, its harmful effects, and the actions that will eliminate it. Importantly, all other aspects of that person (their agency, warmth, individuality, etc.) become less salient, or only salient insofar as they relate to their disease label. In weight stigma, everything about a fat person becomes interpreted through the lens of “obesity” and the mandate to lose weight. This effect is so strong that the most important aspect of a fat person can become who they will be when they eventually lose weight, rather than who they are in the present (Fox, 2018). In medical contexts, the pathologization of fatness overrides the usual cognitive processes of clinical decision-making, leading doctors to interpret all other health issues as actually weight issues, and, as a result, provide fat people with worse care (Phelan et al., 2015).³ Existing weight stigma research suggests that fat people are likely dehumanized in a variety of ways (Bernard et al., 2014; Kersbergen & Robinson, 2019); we posit that the pathologization of fatness contributes to this dehumanization.

1.3 | Limitations of existing weight stigma interventions with HCPs

We assert that it is impossible to understand—much less combat—weight stigma as it currently exists in the United States without understanding its roots in the pathologization of fatness. After medicine gained jurisdiction over weight in the early 1900s (Gilman, 2010; Strings, 2019), pathology became the dominant frame through which fatness was (and is) understood, drawing on the authority of medicine to appear objective (McHugh, 2019). The pathologization of fatness has led to the widespread stigmatization of fat *people*; the effects of this pathologization are most clearly demonstrated in the “war on obesity,” which is a transparent effort to eliminate fat people in the present and future (Boero, 2012; Herndon, 2014). Fat activists and fat studies scholars reject the terms “overweight” and “obese” because they are stigmatizing: they depend on the idea that some weights are normal, natural, and/or healthy while others are abnormal, unnatural, and unhealthy (Saguy, 2014; Wann, 2009). The ubiquity of these terms in medicine, media, politics, education, and even weight stigma research shows just how pervasively fatness has been pathologized (Calogero et al., 2016). This pervasiveness presents an intimidating barrier to weight stigma reduction efforts.

Simply put, there is no way to simultaneously pathologize *and destigmatize* fat people. A pathologizing view of fatness implies that fatness, and thus fat people, should be eliminated. Yet almost all existing weight stigma interventions preserve the pathologization of fatness (see Calogero et al., 2016). For example, articles often begin by reiterating that “obesity” is a deadly disease and the “obesity epidemic” is a global crisis in desperate need of a solution (Kushner et al., 2014; Roberts et al., 2011). Some articles take this claim even further, framing weight stigma as an issue *because* it can lead to weight gain, rather than as a degrading phenomenon in its own right (e.g., Himmelstein et al., 2017). Additionally, weight stigma reduction interventions often rely on explicitly pathologizing educational materials, such as those put out by the Rudd Center (Mollow, 2015; e.g., Swift et al., 2013).

The majority of existing weight stigma reduction interventions for HCPs are based on attribution theory. Attribution theory interventions posit that providing information on causal factors—that is, educational materials about the structural and biological causes of fatness—will reduce the degree to which HCPs blame fat people for being fat, which will then presumably reduce stigma (Alberga et al., 2016, p. 184; Meadows, Higgs, et al., 2017, p. 2). At best, attribution theory interventions shift the blame for fatness to genetics and an “obesogenic environment.” The fundamental problem with these interventions is that they leave pathologization intact and reinforce fat bodies as diseased, which means fat people are still stigmatized (Calogero et al., 2016) and dehumanized (see also Hoyt et al., 2017). Overall, attribution theory interventions for weight stigma have repeatedly failed to produce long-term destigmatizing effects (Alberga et al., 2016; Danielsdóttir et al., 2010; Lee et al., 2014).⁴

Recognizing the limits of attribution theory-based interventions, some researchers have turned to empathy as a potential way to reduce weight stigma. In empathy-based interventions, researchers ask participants to “put themselves in a fat person’s shoes” through techniques such as exposure to first-person narratives (Swift et al., 2013), roleplaying (Matharu et al., 2014), imagination (Dunaev et al., 2018), and experience simulation (Herrmann-Werner et al., 2019; Kushner et al., 2014). Despite their varied methods, empathy-based interventions have been generally ineffective at reducing weight stigma. Danielsdóttir et al. posit that “evoking empathy is a relatively ineffective strategy for anti-fat prejudice reduction because it emphasizes the negative sides of being overweight” (2010, p. 54). We agree, but argue that a stronger claim is warranted: because pathologization involves dehumanizing fat people by reducing them to their disease category, empathy-based interventions that do not challenge pathologization will encourage their participants to *empathize with a dehumanized figure*. In other words, existing empathy-based interventions have failed to produce meaningful reductions in weight stigma because

³For a similar phenomenon, see “trans broken arm syndrome,” in which clinicians attribute all medical issues of a transgender patient to the fact that they are transgender (Pearce, 2018, p. 111).

⁴In recent years, researchers interested in destigmatizing mental illness have produced multiple meta-analyses indicating the problems with using attribution theory to reduce stigma (Kvaale et al., 2013; Loughman & Haslam, 2018). Specifically, attribution theory interventions reduce blame but increase avoidance.

they have promoted a form of *dehumanizing empathy* (see Reisman, 2017 for a particularly striking example). For example, in one study, participants were asked to “read a first-person narrative of an individual with obesity” which “described in detail the numerous struggles that a man with obesity (‘John’) faces in his attempts to lose weight” (Gloor & Puhl, 2016, p. 272). The framing of this narrative reinforces the pathologization of fatness, wherein all that matters about a fat person’s life is their attempts to lose weight, so by providing it as their “empathy-inducing” material, the researchers ask participants to empathize with an already deeply negative and stigmatizing understanding of fatness (see also Niederdeppe et al., 2011; Thibodeau et al., 2017). As a result, this intervention yielded “somewhat pessimistic findings” in which increased empathy did not produce a corresponding reduction in weight bias (Gloor & Puhl, 2016, p. 275).

Weight stigma scholars have criticized interventions that use fat suits to mimic the experience of being fat (Meadows, Danielsdóttir, et al., 2017). These studies can be critiqued in many ways: they do not actually simulate the experience of being fat, they homogenize fat people because participants generalize their experiences in a fat suit to the experience of “being fat,” they implicitly value the momentary, false experience of being in a fat suit over the lived experience of fat people, and they do not appear to be effective (Hales et al., 2018; Incollingo Rodriguez et al., 2016; Luig et al., 2020). As Meadows, Danielsdóttir, et al. state, “If participants in an empathy-building intervention cannot take the perspective of another person without donning a costume to assume the stigmatized identity, then doing so is unlikely to improve the outcome” (2017, p. 275). As in other empathy-based interventions, participants in these studies interpret their experience in a fat suit through the dominant understanding of fatness as pathological, emphasizing the unpleasant and treatment-oriented content of the illness schema. Accordingly, the studies produced negative results; for example, Incollingo Rodriguez et al. found that that participants in their study who wore fat suits reported higher antifat attitudes than the control participants (2016, p. 1,897). Because the donning of fat suits produces dehumanizing empathy, it is more likely to be stigmatizing than destigmatizing.

The direct contact hypothesis posits that intergroup prejudice can be reduced through direct interactions between members of different groups (Pettigrew & Tropp, 2006).⁵ Roberts et al. (2011) paired four medical students with fat people waiting to undergo bariatric surgery, such that the medical student attended every medical visit involving that patient for a year. The authors claimed that this long period of direct contact helped students identify and negate many of the stereotypes they held about “obesity.” For example, one student expressed surprise over their patient being “so goal-directed” and another was shocked to learn that their patient had lost (and regained) weight on six different diets before pursuing surgery (Roberts et al., 2011, pp. 179–180). While this study seems to have

successfully challenged weight controllability beliefs, it also reinforced students’ perceptions of fat people as diseased and convinced them that fat people need more drastic treatment (i.e., surgery instead of low-calorie diets) (Roberts et al., 2011, p. 180). It did not humanize fat people.

1.4 | Eradicating weight stigma

A fat studies approach to weight stigma research necessitates a deep, normative shift in existing research goals and practices. The goal of weight stigma interventions should not be limited to producing a statistically significant reduction in some measure of stigmatizing beliefs or attitudes. Rather, the goal should be to *eradicate weight stigma entirely* by using interventions that undermine stigma and aspire to manifest a world without it. This does not mean that every intervention must get rid of all weight stigma,⁶ nor does it simply involve a quantitative increase in effect size. Rather, it means that all interventions should be designed such that they help bring about a world without weight stigma, meaning that even interventions focused on interpersonal interactions can and should still challenge the underlying foundations of weight stigma. Any efforts to reduce weight stigma should be depathologizing and humanizing.⁷ Moving toward a world without weight stigma also entails a reevaluation of the research process. According to the principles of research justice (Cooper, 2013), interventions designed to eradicate stigma should (a) involve collaboration with members of the stigmatized community, (b) create situations where stigmatized groups are respected and can benefit both directly and indirectly from participation, and c) make findings accessible to stigmatized groups.

Direct contact as a method for prejudice reduction can be aligned with the principles of research justice to focus on depathologizing and humanizing fat people. Existing research suggests that intergroup contact can increase the humanness attributed to outgroups (Capozza et al., 2014), so interacting with fat people directly in a depathologizing context means that HCPs can be exposed to more dimensions of fat people than just their “disease.” Researchers have also found that intergroup contact lowers prejudice in part by reducing the level of negative affect associated with the outgroup (Pettigrew & Tropp, 2008). Stigma rooted in pathologization trains individuals to associate fat people with negative emotions like disgust and resentment (Stangl et al., 2019), and studies have shown that medical education strengthens this embodied response (Blumberg & Mellis, 1985; Ip et al., 2013). Most HCPs interact with fat people frequently as patients yet remain prejudiced against them (Meadows, Higgs, et al., 2017, p. 3). Although researchers have argued, contra

⁶We recognize that the origins of weight stigma are far too broad and varied to be tackled in any one intervention (see MacKean & GermAnn, 2013; Setchell et al., 2017).

⁷To be clear, when we propose combating pathologization, we are not proposing that researchers assert that all fat people are healthy. The problem of pathologization is that fat people become defined by their status as diseased, which is dehumanizing. Justifying fat people’s humanity based on their potential ability to be healthy implies that unhealthy fat people still deserve to be treated badly (Mollow, 2015). Unbiased, compassionate healthcare should not be tied to perceived health status.

⁵In this case, the groups in direct contact are fat people and HCPs. However, this formulation is complicated by fat HCPs, who may be at once subject to and perpetrators of weight stigma, as their training teaches them that their own bodies and bodies that look like theirs are inherently diseased (Majdan, 2010).

Allport (1954), that equal status in intergroup contact is helpful but not necessary (Pettigrew & Tropp, 2006), we believe that leveling the power asymmetry between HCPs and fat people is crucial for weight stigma interventions. Direct contact interventions should create the opportunity for mutual vulnerability and mutual benefit between HCPs and fat people. If pathologization depends on the power of medical authority, a depathologizing weight stigma intervention must create situations that take HCPs out of the expert role, empower fat people to speak from their own expertise, and thereby make space for HCPs and fat people to interact on equal terms.⁸

1.5 | Narrative medicine workshops as a humanizing method of direct contact

We developed an intervention based on the tools of narrative medicine to create a space for complex, humanizing interactions between fat people and HCPs. Narrative medicine is a field dedicated to teaching clinicians “the narrative competence to recognize, absorb, interpret, and be moved by the stories of illness” (Charon, 2006, p. vii).⁹ In a narrative medicine workshop, a trained facilitator guides a group of HCPs (or occasionally patients) through the process of a) reading, discussing, and interpreting a literary text, b) writing short responses, and c) discussing these writings with each other. We adapted this practice for the purpose of addressing weight stigma by shifting the focus from developing a clinical competency to using the workshop format as a direct contact intervention. Specifically, narrative medicine workshops almost never involve interactions between HCPs and people who are not HCPs (cf., Chou et al., 2020), and they usually involve texts chosen not for the relevance of their content, but for their utility in training skills of literary analysis. As such, narrative medicine workshops often exclude the patient stakeholders who would presumably benefit from clinician education (see Banner, 2017), just as weight stigma reduction interventions exclude fat people in their design and execution. Our intervention, designed by a medical student concerned about the weight stigma in her curriculum (Park) and a fat activist/narrative medicine practitioner (Fox), melded together insights from social psychology and narrative medicine in a way that could counteract their respective limitations.¹⁰

⁸However, researchers should recognize that putting fat people in direct contact with HCPs entails a risk for fat people. The best way to manage this risk is by including fat studies scholars and/or fat activists—the people with the most expertise regarding the dehumanization of fat people—in the research design process. Additionally, fat participants should be compensated adequately for their labor.

⁹Narrative medicine is a literary practice distinct from medical treatment, psychological treatment, and narrative therapy. It does not involve providing care, counseling, or otherwise alleviating medical symptoms.

¹⁰To embody the principles of stigma eradication and research justice, the workshops were facilitated by the authors (Fox and Park), ready to intervene if participants stopped treating each other respectfully. Participants were surveyed before the first meeting about their accessibility and comfort needs. To meet these needs, and to stage the workshops in a non-clinical context, sessions were held in a conference room with a variety of furniture that could accommodate diverse bodies. During the first workshop, the facilitators laid out a set of guidelines for building community, including confidentiality and being mindful about who is talking and who is not. Overall, the intervention was designed for HCPs and fat people to be in proximity in a radically different way

The practices of narrative medicine are well-suited to de-pathologizing fatness in the context of a stigma intervention. First, in each workshop, participants are engaged in the shared task of interpreting a text¹¹ and discussing how its form, plot, and other literary components contribute to its meaning. Existing research suggests that collaborative work on a shared task contributes to the decrease in prejudice from direct contact (Pettigrew & Tropp, 2006). Importantly, the task of literary analysis is unfamiliar to both fat people and HCPs, and all participants are asked to share creative writing produced during the workshop, a generally daunting act. These kinds of activities remove medical authority, reducing interpersonal power imbalances and creating space for mutual vulnerability and novel interactions. Talking about how a text makes meaning creates a shared object for discussion while also allowing participants to disclose personal responses grounded in their experience. Moving back and forth between the text and personal responses allows for both intimacy and distance in a discussion, such that participants can talk about their feelings without having to report on them directly. For example, a participant would be encouraged to say, “The author uses this metaphor to express sadness to her reader” rather than “This poem makes me feel sad.” This can be understood as a form of “self-distancing,” which has been shown to dampen emotional reactivity and make it easier to self-reflect in an adaptive way (Ayduk & Kross, 2010). Research has shown that “expressive writing,” like the writing activities used in narrative medicine, has similar effects in part through the same pathway of self-distancing (Park et al., 2016; Pennebaker, 1997).

2 | METHOD

2.1 | Participants

The study design was approved through the University of Southern California Health Sciences IRB. First- and second-year medical students at the Keck School of Medicine of the University of Southern California were recruited using school-wide email listservs and Facebook groups. Individuals who self-reported experiencing weight-based discrimination from a healthcare provider were recruited from California-based fat activist Facebook groups and word-of-mouth in the online fat community. In addition to being provided food and parking, all participants were compensated financially at the end of the workshops (\$50 per medical student, \$200 per community member). Initial recruitment comprised four medical students and three community members. One community member dropped out after the first session due to employment demands. At the first session, participants filled out a form with demographic information (see Table 1). The participants were not asked what term

¹¹When we say “texts,” we are not necessarily referring to written material. Images, sounds, and videos, etc. can also be the “texts” analyzed in a narrative medicine workshop.

TABLE 1 Demographic characteristics of participants

Participant	Age	Gender	Ethnicity	Experienced size discrimination	Witnessed size discrimination
Medical students					
1	28	Woman	Asian/Pacific Islander	Yes	Yes
2	25	Woman	Black	No	Unsure
3	23	Man	Asian/Pacific Islander	Unsure	Yes
4	–	Woman	Asian/Pacific Islander	No	Unsure
Community members					
1	54	Woman	Mixed (White/Latinx)	Yes	Yes
2	36	Woman	White	Yes	Yes
3 ^a	47	Woman	White	Yes	Yes

Note: Responses that were not provided by the participant are marked with a dash.

^aThis participant dropped out after the first workshop.

TABLE 2 Participants' scores on the fat phobia scale

Participant	Pre-workshop	Post-workshop	Difference
Medical students			
1	3.07	3.00	–0.07
2	3.21	2.21	–1.00
3	3.38	2.86	–0.52
4	3.29	2.93	–0.36
Community members			
1	2.50	1.93	–0.57
2	3.00	3.00	0.00

they would use to describe their bodies on the demographic form. However, over the course of the workshops, the participants talked about how they referred to their own bodies: one community member identified as “fat,” the other identified as “overweight,” and all four medical students identified as “thin.” In order to assess their attitudes toward fat people, the *Fat Phobia Scale—Short Form* (Bacon et al., 2001) was administered to all participants at the beginning of the first workshop session and after the last workshop. However, because of the small sample size, we do not discuss these results any further (see Table 2).

2.2 | Materials and procedure

2.2.1 | Workshop structure

In July and August 2017, study participants met for 2-hours narrative medicine workshops once a week for five weeks; all workshop texts and writing materials were provided to participants. After a short meal, the week's text (see Table 3) was distributed or projected and written texts were read out loud by workshop participants. Next, facilitators led a discussion of the text centered

around its literary aspects, such as genre, tone, diction, and use of figurative language. After approximately 45 minutes of discussion, facilitators provided a writing prompt (see Table 3) and asked each participant to write whatever came to mind for 5 minutes. Participants were encouraged to read their writing out loud to the group. If they invited feedback, other participants discussed the literary components of their response and what elements of the writing were impactful. We chose texts that specifically dealt with experiences of being fat rather than unrelated literary works or didactic medical information. Thus, while analyzing and interpreting how these texts make their meaning, participants also had the indirect opportunity to think about the nuances and complexities of living a fat life. By focusing on language and grammar, they did not have to evaluate the story's utility or veracity, but they had the chance to think deeply about it in community with the other participants. Since there was no right or wrong or didactic information to take away, these discussions were designed to encourage participants to show up and engage with one another in their full, multidimensional humanity.

At the end of the first workshop, participants were given a take-home writing assignment: “Write about a time you witnessed, participated in, or experienced fatphobia in a clinical encounter.” Participants were informed that they would be asked to write about the same experience every week in between the workshops in a different style or format and that they would be asked to bring these writings to the following workshop. In week 2, the workshop followed the same structure until the final 20 minutes, when participants were asked to form triads (two medical students and one community member) and read and comment on each other's writings from the take-home assignment. Before leaving, another take-home writing prompt was distributed. This structure was repeated in weeks 3, 4, and 5. For example, after analyzing a poem at the start of the second session, participants were asked in their take-home prompt to rewrite their narrative of fatphobia in a clinical encounter as a poem and bring this poem to the third session for discussion in their triad.

TABLE 3 Workshop texts and short writing prompts

Week	Theme	Text	Prompt
1	Foundations	Edward Thompson, "A morbidly obese patient tests the limits of a doctor's compassion" & Sayantani DasGupta, "The Shame of Fat-Shaming"	Write about a time you felt cared for
2	Poetry	Elle Hill, "Morning Meeting"	Write about a time you felt stuck.
3	Spoken Word	Samantha Peterson, "Dead Men Can't Catcall"	Write about a time you took up space
4	Visual Narratives	Nona Faustine, "White Shoes"	Write and/or draw about a time you felt sacred
5	Creative Non-Fiction	Roxane Gay, "Butcher Block"	Choose a sentence or phrase from "Butcher Block" to be the opening of your narrative

2.2.2 | Focus group interviews

Medical students and community members were interviewed in separate focus groups one week after the workshops ended. A research mentor (Vo) who had not previously met the participants facilitated the 90-minute focus groups. Focus group questions were developed to gather information about participants' views of the integrated narrative medicine and direct contact approach to reduce weight stigma. In both groups, the first four questions probed general understanding of weight stigma in healthcare and in broader society; the next five questions asked about participant reactions to the use of narrative methods for addressing weight stigma; the next three questions asked about the usefulness of direct contact and collaboration; and the final six questions collected ideas for overcoming weight stigma in healthcare. Medical students were asked an additional six questions about the relevance of narrative medicine to their formal medical curriculum. Primary investigators were not present to ensure open and unbiased dialogue. Audio recordings were later transcribed using Rev, an online transcription service.

2.2.3 | Group reflection

At the end of the fifth workshop, participants also engaged in an unfacilitated 10-minute whole group reflection. The workshop facilitators (Park and Fox) provided several discussion prompts, asking participants what they were going to take away from the workshops and if they had any final reflections for each other. Participants consented to being recorded and facilitators left the room while the discussion took place. This short discussion was then manually transcribed.

2.3 | Data analysis

Thematic analysis, an iterative qualitative method for organizing, describing, and reporting themes within textual data, was conducted on the focus group data using NVivo software (Nowell

et al., 2017). After a general interaction with transcripts and consultation of workshop facilitation notes, initial codes were developed by authors Fox and Park, first independently and then consolidated after debriefing and defining codes. Themes (broader categorizations of codes relating to research aims) were generated in a similar fashion—that is, through a second, independent review of data using agreed-upon codes by each researcher with subsequent consolidation after setting theme definitions.¹² A year later, we revisited the data and used abductive analysis in order to rework these themes. Abductive analysis is a qualitative approach that focuses on theory-generation by attending to "anomalous or surprising empirical findings" against the background of existing theories (Timmermans & Tavory, 2012, p. 169). Because the theories underlying existing weight stigma interventions were not sufficient for making sense of our qualitative data, we used abductive analysis to generate a new theoretical framework guided by fat studies (see above).

3 | RESULTS

3.1 | Grappling with pathologization

Focus group interview data demonstrated that our workshops created an opportunity for medical students to think critically about the causes and consequences of the pathologization of fat people. When asked to define fatphobia¹³ and speculate on why it exists, the medical students provided broad, complex definitions that acknowledged interpersonal (misunderstanding, discomfort), social (stereotyping, negative media portrayals), and structural (medicine as "normalized" for thin, White, male bodies) discrimination against fat people. These definitions show an understanding that weight stigma does not simply depend on the idea that weight is individually controllable, but

¹²Additionally, we have excluded analyses of participant writings at this juncture because we did not initially conceive of approaching them as data when we assigned them, and have not yet developed a way to honor their efforts with an appropriate analytical method (in particular, a method that does not jeopardize anonymity).

¹³The interview questions used the term fatphobia, but fatphobia, weight stigma, and fat stigma were used interchangeably during the focus groups.

rather that it is upheld in many realms of life, including medicine. Medical students also specifically cited how assumptions that all fat people are unhealthy, and the medical authority invoked in those assumptions, perpetuate the stigmatization of fat people. One student unpacked how the word overweight “implies that there’s a normal weight,” which contributes to stigma, while another discussed the “extra power dynamic” between an HCP and a fat person, explaining how an HCP claiming that all fat people are diseased comes across as “more factual and more conclusive, which could definitely lead to more shame” about being fat.

Medical students also reflected on how the pathologization of fat people can prevent them from receiving adequate medical care. One student commented on how their curriculum encouraged them to make quick judgments about fat people’s ill health through the use of mnemonics like “fat, forty, female [in reference to gallbladder diseases].” This student drew an explicit connection between the use of such phrases and the way diagnostic shortcuts discourage HCPs from soliciting fat people’s individual stories and medical histories. Another student recounted stories from the community members about how their medical issues were overlooked by doctors because of their weight. The medical students felt that their curriculum encouraged them to define fat people by their fatness and thus prescribe weight loss as “the solution for every disease or illness.” However, they also recognized that there “seems to be a lot of distrust with what fat patients might say,” so even if fat people try to tell their own stories, their experiences may be discounted.

3.2 | Humanizing interactions

Participants also reported that the workshops facilitated humanizing interactions between medical students and community members. Medical students expressed gratitude multiple times for the chance to hear directly from people with unique knowledge about “the fat experience.” However, while they valued this opportunity, they also recognized the risk the community members took to address medical students when community members had all reported negative experiences with HCPs. In the group reflection, one medical student expressed his admiration for their courage directly to the community members: “I don’t know how exactly they recruited for this, but ... I really appreciate you for being here and being brave enough to own your story and have the courage to be vulnerable with us. I really appreciated in general just how the rapport has built.” When a group is dehumanized, their perceived capacity to suffer can be minimized (Waytz et al., 2010). This quote recognizes not only the community members’ capacity to suffer, but also the history of their suffering at the hands of the medical establishment. It also shows that this medical student recognized the community members as agential (choosing to participate in the study) and generous (giving their time and insight to the medical students), two qualities that can be minimized in the process of dehumanization (see Haslam & Loughnan, 2014).

Another important aspect of humanization is acknowledging the individuality of members within a group. Medical students reported that the workshops helped them see how important it is to solicit and respect fat people’s stories. In the words of one student:

I think before the workshop, I underestimated how much every community member had heard the same thing from every doctor they saw. Even if every doctor had good intentions when they said, “maybe you should exercise,” [the community members] had already heard it so many times before that it just became white noise. I think I would want to keep that in mind whenever I talk to patients, that I’m not the first doctor that they’ve seen and if I want to really have an impact on them, I need to think carefully about individualizing my care and making sure I’m not just saying the same thing everyone else has said and being specific to their needs.

This quote starts with a recognition that fat people’s typical experience with HCPs is one of dehumanization: fat people are not treated as individuals but rather are given the same advice (exercise) over and over because their weight is their defining feature. The student then determines that, if they want to help fat people in their future medical practice, they must break this pattern of dehumanization by paying attention to fat people’s individuality and “being specific to their needs.” This quote shows that the medical student, after participating in the workshops, is invested in the particularity—and thus the humanity—of fat people, including their future fat patients.¹⁴

3.3 | Medical students putting themselves in community members’ shoes

Both medical students and community members reported that the narrative-centered, collaborative workshops provided a space for them to empathize with one another. One medical student explained: “[T]he narrative part was important but what I learned more from was the random conversations that these narratives helped us have ... [T]hat interaction helped grow the sense of empathy more, the activities around it.” Another medical student described how the discussions deepened their capacity to engage with the texts in an empathetic way, stating, “[T]he act of trying to understand the point they’re making and then, in that sense, reach them halfway is an act of empathy and trying to understand their point of view.” When asked to explain what they had learned

¹⁴Although this section focuses on the humanization of fat people, this quote hints at how medical training based on de-individualization might also erode the individuality—and thus the humanity—of providers, who are required to put aside their personal experiences and submit to homogenizing practices such as diet and weight counseling.

and how they had been affected by the workshops, participants frequently referred to both the texts they engaged with and the stories different people shared during the workshops. In other words, participants' retrospective impressions of the workshops were deeply intertwined with the opportunities they had to take the perspectives of others. This suggests that the narrative medicine structure made space for participants to empathize with each other through textual analysis, relating to others' responses to the texts, reading other participants' writing, and conversations that allowed participants to express their experiences of the world and respond to what others saw in those experiences.

The experiences of empathy that participants reported diverge in important ways from the empathy generated in existing weight stigma research. As we previously argued, existing empathy-based weight stigma interventions have not been successful because they produce dehumanizing empathy. In contrast, because the experiences of empathy in our intervention emerged from complex, open-ended interactions with actual fat people, this empathy took a form that was contextualized, individualized, depathologized, and generative. For example, one medical student emphasized how impactful it was for them to learn about the "lived experience of being someone of different size":

When Community Member B used to stand up, that table has to be far enough for her to hold onto. All of these things help me realize that this experience is very much flesh and blood. There's a different way of moving in the world about it. This society isn't necessarily constructed to give that experience the easiness that it deserves.

Compare this with a superficially similar quote from a participant in a study where HCPs wore fat suits in an attempt to generate empathy for their fat patients:

I'm going to make damn sure that they're comfortable about sitting down! I'm going to make sure that there's a big enough seat for them and that it's not gonna move when they sit on it. I'm going to make sure that they've got thousands of tissues to mop up the sweat. That whole spatial thing of remembering that they can't see their feet. And give them time. Because getting somewhere is going to be so exhausting that you can't expect them to do anything straight away.' Cause actually they're going to need 5 minutes to recover. (Hales et al., 2018, pp. 22–23)

First, the medical student refers to their interaction with a specific individual (Community Member B), while the quoted HCP's experience in a fat suit is generalized to all fat people ("they"). Second, the medical student uses neutral language that implies an acceptance of body diversity, referring to a "different way of moving in the world," whereas the HCP describes being fat as intrinsically difficult and debilitating.

Finally, the medical student implies that society and the built environment impede fat people's right to exist and move around with ease, while the HCP discusses the importance of accommodations as a concession to fat people's inferior embodiment. In sum, the empathy of the medical student is based in respect and a shared sense of injustice, while the "empathy" of the HCP is deeply stigmatizing and rooted in pity.

Medical students also indicated that their analysis of the workshop texts helped generate the kind of empathy described above. For example, one student reported that the narratives communicated a particular feeling or experience from a fat person's point of view: "A lot of times the prevailing anxiety was something like 'people only see me for being fat, they don't see me as anything else.' Understanding that that was anxiety ... and feeling that yourself ... definitely increased my empathy." The medical student described empathizing with the experience of being discriminated against, of being stigmatized, rather than empathizing with suffering as intrinsically caused by being fat. Similarly, another student talked about empathizing with a specific poem ("Morning Meeting," see Table 3):

A short synopsis of it is that it basically follows a fat poet who is sitting in a small classroom desk and really feels like she's suffocated by it, which the poem's structure, as well as diction were able to convey or really, really underscored. In terms of empathy, I did under—or I personally could feel myself sitting back in that little school chair, feeling as if all eyes were on me, even if that wasn't necessarily the case, and feeling really insecure about what was going on and being potentially hated by people who were around me. A lot of insecurity came out and I think that insecurity met with the insecurity she was trying to convey, there was a form of empathy in that.

Here, the medical student empathizes with an experience depicted by an actual fat poet (i.e., the empathy is individualized, rather than claiming to represent all fat people). The empathy is contextualized, in that the medical student connects the suffering of the fat person depicted in the poem to their stigmatizing environment. Rather than pitying the fat character in the poem as a helpless victim of a disease, the medical student identifies with the insecurity that comes from the feeling of being out of place. Moreover, the student explicitly identifies that the formal aspects of the poem (its structure and diction) helped them grasp its meaning, which suggests that the practice of close reading was tied to the skill of perspective-taking.

Importantly, although we did not provide didactic instruction regarding how to interact with fat people, medical students drew organically on their empathic experiences to generate new ways of relating to fat patients. For example, one medical student discussed how the texts and stories from the community members "emphasized the fact that people constantly are shaming them every day." Thus, the student concluded:

[T]here's no need as a doctor to add to that, especially, for example, [if a patient is] coming in for a pelvic exam, there's no reason to bring up their weight or give them a pamphlet for how to lose weight. It's one thing if they're coming in asking the doctor about ways to lose weight, but if they're coming in for some other problem that's totally unrelated, just hearing these stories has solidified the idea that there's no reason to bring that up in any sort of way.

The medical students were building on their experiences of empathizing with the community members and workshop materials to anticipate the needs and desires of the fat people they might encounter in the future. Large bodies of psychological research have found that beliefs and attitudes developed through one's own extended effortful cognitive processing are more likely to be remembered and more likely to shape future behavior in the long term (Craik, 2002; Petty & Cacioppo, 1986). Their experiences of empathy seem to have motivated the medical students to engage in deep, effortful cognitive processing of the meaning of the stories they read and heard. In other words, the medical students came to see fighting against weight stigma in healthcare as their own responsibility, and they believed they had the knowledge and tools needed to take on that duty.

3.4 | Balancing power for mutual benefit

Based on the principles of research justice, it is also important to report the experiences of the community members in these workshops. The qualitative efficacy of the intervention cannot be judged without accounting for its impact on community members. In their focus group, the community members discussed the ways they found the intervention subjectively beneficial. For example, one community member explained: “[It] was heartwarming to me to have people be so empathetic and open-minded to me. I actually feel like they felt my pain and that they cared for us.” Both members reported feeling moved by interacting with the medical students; as one phrased it:

I'm super glad I was included, and I got to participate, and I really, really enjoyed every aspect of it. The parts that made me think, the parts that made me create. Some of the material I had seen before ... but it was eye-opening to hear a lot of the analysis that came from everyone in the group and their thoughts. It led to a deeper understanding even for me as a longtime size activist.

The community members reported that the writing they did in and out of the workshops was rewarding; one member recounted feeling deeply gratified by a moment in her take-home writing when she found a new metaphor that helped her communicate the experience of being discriminated against because of her weight. Finally, community members appreciated the chance to feel like they were shaping

future doctors and giving them perspective on something they had not previously considered. In other words, community members reported receiving satisfaction from the chance to be the experts on their own lives, and to speak with medical students who respected—and learned from—that expertise.

Relatedly, the medical students reported benefiting from stepping out of the expert role and having the opportunity to be open and vulnerable about their thoughts and experiences. One student felt the workshops contributed to both personal and professional growth: “[I]t's been not only a tremendous growth in terms of understanding fat stigma in medicine but also I think it's really helped me to understand some of the things that I've experienced and how to put words to that.” There was one exchange between a student and a community member that was so meaningful to participants that it came up in both focus groups. In the exchange, the medical student shared a story about being sexually harassed by a fat man during his time working in a clinic. Reflecting on the moment after he shared, the student recounted:

I was afraid of what my [community member] partner would say. She ended up saying “No, it sounds like you did the best thing you could, it sounds like that guy was a jerk,” which was honestly really a relief, that she felt that way. Maybe in the situation it wasn't about the weight, it was about his character.

The community member described the exchange similarly:

The student was saying how he felt really bad for the man but he didn't know if he was wary of being around the man because he was fat. I was like, “No. You're wary being around the man because he told you that he would bite you. He was sexually harassing you. That's why you were wary of that.” He said, “Thank you for validating me and validating the fact that it was okay for me to be hands-off and that it wasn't because of his size. It was because he was just a jerk.” I'm glad that we were able to have that sharing because he seemed like a very tender-hearted person and I think it bothered him that he might have been seen as being discriminative [*sic*] towards that person because they were big.

These quotes show a moment in which *validation from a community member* helped a medical student process a troubling experience. In other words, the space of the workshops provided an opportunity for participants, *as equals*, to provide comfort and support to one another. Another student described how the group analysis also helped create collaborative relationships among participants: “I think having an artwork that we were all reading and analyzing together made us feel like we're all coming together on equal footing to talk about a piece of art, which allowed the conversations to flow.” Though it is difficult to qualitatively investigate power dynamics between two

groups using data from separate focus groups, these quotes suggest that the medical students did not have power over the interactions. In some interactions, it appears that community members had the power to affirm the conduct and assuage the anxieties of the medical students.

4 | DISCUSSION

Our qualitative findings suggest that our intervention created the depathologizing, humanizing, and empathetic interactions that we theorized are important for eradicating weight stigma. Using direct contact structured by narrative medicine workshops, we formed a small space where the power of medical authority was temporarily undermined, as evidenced by the way that the medical students reflected critically on their training and respected the expertise of the community members about their lived experience. Through the process of reading and analyzing texts created by and about fat people, discussing those texts with community members, and sharing their own written responses, medical students appear to have experienced humanizing empathy for fat people that was contextualized, individualized, depathologized, and generative. The medical students described empathizing with specific struggles experienced by fat writers and community members, and they were able to use these experiences to craft strategies for combating weight stigma in their own future medical practice. The responses of the medical students indicate that they recognized fat people as complex, agentic, knowledgeable human beings capable of suffering and kindness. Even though our qualitative data cannot disentangle the impact of the narrative medicine structure from the effects of direct contact itself, there was some preliminary support for the hypothesized utility of narrative medicine as a way to structure humanizing, empathetic interactions. Members from both groups reported learning and growing from this experience, which indicates that participating in this kind of intervention can be valuable for *both* medical students and fat people.

There are several limitations to this study. First, since this was a small pilot study, quantitative measures of weight stigma before and after the intervention could not meaningfully assess its effectiveness in combating weight stigma. Second, we cannot say with certainty whether some of our qualitative findings reflect changes that resulted from the intervention or pre-existing views of the medical students; it is possible that the medical students who participated were especially receptive to this type of intervention.¹⁵ Third, it may be significant that our participants were medical students and not fully trained HCPs. According to our theoretical framework, it may be more difficult to achieve the kind of leveling of power and status that is likely key for direct contact to counter

pathologization-based stigma. Fourth, we had trouble with recruitment and participant drop-out, which also led to a lack of diversity. Our original goal was to recruit 10–14 participants (half community members, half medical students), but after one community member dropped out, our sample consisted of only six participants. Also, the medical students noted the lack of diversity among the community members and suggested that future interventions involve a more diverse group of fat people, as the community members were both cisgender women, one White and one mixed-race (White/Latinx). Finally, our intervention is clearly time-consuming and resource intensive.

However, we believe that many of these limitations could be addressed in future research. First, a quantitative study using a similar intervention with a larger sample of participants (in groups of approximately 12) would be valuable. We recommend such a study use the Fat Attitudes Assessment Toolkit, a new scale designed based on insights from fat activism and fat studies and which therefore mirrors many of the ideas that were used to design this intervention (Cain, 2019). Second, to improve recruitment, researchers could emphasize the potential benefits to participants. Though our recruitment materials did not highlight this aspect, narrative medicine workshops do provide training in valuable clinical skills for medical students and HCPs (Charon, 2001), and our hybrid workshops had all those features. Similarly, because the community members found the opportunity to shape the views of future doctors particularly meaningful and empowering, this message could be incorporated into materials used to recruit participants from fat activist communities. Regardless, community members should be well-compensated for their emotional labor and expertise. We also encourage all researchers to include a diverse range of fat people, as someone who is a size 36 will have very different insights to share than a someone who is a size 26 or 16 (Ash, 2016).

As a qualitative pilot test of a new weight stigma intervention, we found our workshops were successful at creating the kind of social interactions that we theorize are likely to combat stigma, undermine pathologization, and undo dehumanization. In other words, our pilot test did not uncover any major flaws in the design of the intervention itself, and we believe that using narrative medicine workshops as a structure for direct contact interventions is profoundly promising. Nevertheless, there are a few minor changes that could improve the intervention. In the first session, facilitators should give each participant the opportunity to talk about the terms that they use to refer to their own bodies. Additionally, as not all participants may feel comfortable with literary analysis, the facilitators should provide additional resources (e.g., Charon, 2006, pp. 107–129) to ensure a baseline understanding of close reading. In general, we advise against shortening the length of the sessions or duration of the intervention. Having the time to build up relationships and make space for vulnerability is crucial.

This intervention could be institutionalized as an elective narrative medicine course for medical trainees or as a continuing education course for medical professionals. However, we recommend that such a course remain *elective*, as the presence of individuals deeply

¹⁵However, we would argue, even if our results represented medical students' pre-existing openness to this kind of intervention, it is still significant that they were given a venue in which to examine and develop their beliefs and feelings about fat people.

committed to the dehumanization of fat people would likely poison the entire experience. We also believe that any future applications of this particular method should be designed and facilitated by at least one fat activist or fat studies scholar and one trained narrative medicine practitioner. More generally, researchers could use a similar approach to combat stigma among HCPs toward other pathologized groups (e.g., transgender people and disabled people). Regardless, we believe direct contact in a depathologized setting should be one of the primary approaches that researchers deploy in weight stigma interventions.

We also offer a new theory of pathologization for understanding weight stigma and other forms of stigma based in the institutional power of medicine. We hypothesize that pathologization involves (a) illness schemas embedded within everyday processes of social cognition, (b) the dehumanization of a group categorized as pathological, and (c) interventions designed to end or prevent the existence of that group. We urge social psychologists to test these hypotheses and investigate the claim that the accessibility and salience of an obesity disease schema is linked to the dehumanization of fat people as well as negative beliefs and attitudes toward fat people more generally. As an interdisciplinary team of researchers, we believe that social psychologists have an important role to play in understanding the interpersonal dimensions of weight stigma and fat oppression. As research into stigma and prejudice has expanded to study a wider range of social groups, the limitations of existing theoretical frameworks, such as attribution theory, have become apparent. Social psychology, as a field that was built primarily around the study of prejudice based on race, ethnicity, and gender, needs new theoretical approaches that investigate the distinctiveness of stigma rooted in medical authority.

All weight stigma interventions must begin from the premise that *fatness is not pathological*. Anything less is merely perpetuating the oppression of fat people at the hands of the institution of medicine. We believe in the good intentions of the researchers designing these interventions. But if these good intentions are to produce good results, by which we mean *better lives for fat people*, weight stigma researchers must reckon with their own role of perpetuating weight stigma to date, including the widespread use of the pathologizing terms “overweight” and “obese” (Calogero et al., 2016). The simplest, and necessarily first, step toward this reckoning is the inclusion of fat people, fat studies scholars, and fat activists in this research at every level: conception, design, implementation, interpreting results, and reporting findings (Cooper, 2016; Pausé, 2020).¹⁶ Fat people do not need to be healthy or hardworking or any number of other counter-stereotypical traits to be worthy of dignity and respect; portraying them as such is not opposing oppression, it is merely constructing another set of criteria by which to deem some fat people worthy and others unworthy. Fat people will not be liberated by pity or patronization. The goal of weight stigma research should be the

eventual creation of a world without stigma. Such a goal commits researchers to three practical imperatives. First, researchers should strive to develop interventions with effects that are practically significant and not just statistically significant. Second, researchers should not design interventions that rely on and/or reinforce the structural basis for weight stigma. Said differently, it is impossible to use medical authority to combat stigma that is derived from medical authority; weight stigma interventions should not attempt to replace one model of obesity with another model (e.g., attribution theory). Finally, weight stigma research should treat fat people the way that fat people would be treated in a world without weight stigma.

CONFLICT OF INTEREST

We have no conflict of interest to disclose.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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¹⁶Fat people should also be the point of contact for media inquiries about any weight stigma research.

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