

A High-Risk Body for Whom? On Fat, Risk, Recognition and Reclamation in Restorying Reproductive Care through Digital Storytelling

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ABSTRACT

This paper explores issues of weight stigma in fertility, reproduction, pregnancy and parenting through a fat reproductive justice lens. We engage with multimedia/digital stories co-written and co-produced with participants involved in *Reproducing Stigma: Obesity and Women's Experiences of Reproductive Care*. This mixed methods research project which took place between 2015-2018 used interview and video-making methods with women-identified and trans people, as well as interviews with healthcare providers and policymakers to investigate perceptions and operations of weight and other stigma in fertility and pregnancy care. We consider the ways in which reproductive risk is typically storied in healthcare and culture, and analyse multimedia/digital stories made by participant-video-makers which story reproductive wellbeing differently. We examine three major themes—on risk, on recognition of weight and other stigma, and on reclamation of bodies—that emerged as critical to these storytellers as they navigated fatphobia in reproductive care. We argue that just as healthcare practitioners strive to practice evidence-based care we must also put into practice *storied care*—to believe, respect and honour fat people's stories of their bodies and lives as fundamental to achieving equity and justice in reproductive healthcare.

Keywords: reproductive obesity, risk discourses, reclamation practices, multi-media storytelling, fat justice, storied care

To watch the stories presented in our paper, go to <https://revisioncentre.ca/high-risk-body>. Following the prompts, type in the password 'reproducing stigma'. Please note: these videos are intended for readers and classroom learning only and are not for broader public screening.

INTRODUCTION

At a 2011 meeting of the Canadian Fertility and Andrology Society in Toronto, fertility specialists debated a policy that would deny fertility services to patients classified as 'obese' (Abraham, 2011). Citing research findings that suggested that fat¹ women have higher medical risks and lower success rates than thin women when trying to become pregnant through fertility treatments such as in-vitro fertilisation, some specialists urged an across-the-board denial of care for those above a certain Body Mass Index (BMI). Other specialists counter-argued that such fertility treatments did not pose unacceptable risks for this population, and that refusing care based on a high BMI alone exacerbated the discrimination that fat women already confront—both in and outside of the medical system. By the end of the meeting, doctors failed to reach consensus on clinical practice guidelines.

¹ Since the term 'obesity' frames fatness as a medical pathology, we avoid this language unless we are referring to the condition as defined by obesity science. Since 'fat' is the preferred language for fat activists and critical obesity/fat studies scholars who aim to reclaim the word as a morally-neutral descriptor, we use fat where we describe people's embodied experiences of non-normative size.

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Since that meeting, debates about BMI cutoffs for fertility and pregnancy care have continued to rage among fertility and obstetrical specialists. In July 2018, the Canadian Fertility and Andrology Society attempted to settle the dispute once and for all by approving a set of practice guidelines for providing fertility and pregnancy care to patients with a high BMI. Although the authors of the document took pains to categorise each recommendation they made as ‘strong’ or ‘weak’ based on the quality of the existing evidence (ranked as ‘high’, ‘moderate’ or ‘low’), they paradoxically proceeded to classify every recommendation as ‘strong’, despite determining that the quality of the evidence for virtually all recommendations (except for one concerning erectile dysfunction risk in fat men) was moderate to low (Mahutte et al., 2018). Insofar as they wallpapered over the considerable uncertainty that exists in the obesity science about the health risks of high BMI during pregnancy, these clinical practice guidelines reveal as much about the politics of weight they do about any possible pathological effects of ‘reproductive obesity’.

Discourses about the health risks of high weight in pregnancy, ranging from increased infertility and miscarriage to gestational diabetes, preeclampsia, and cesarean section have spread far beyond the ranks of the medical community (Catalano and Shankar, 2017). Risk discourses circulate among midwives, nurses and others involved in the continuum of reproductive care, and appear in policy documents, midwifery and medical practice guidelines and popular accounts (see Cook, LaMarre, Rice and Friedman, 2019). Often the medical, clinical and popular media flag the safety of fetuses when bodies labelled as overweight/obese become pregnant, extrapolating from the confounding evidence those studies that identify risks for offspring, including prematurity, macrosomia, diabetes, spina bifida, autism and even stillbirth (Catalano and Shankar, 2017). The heavy emphasis on risk is symptomatic of expert concerns about the effects of BMI on conception and pregnancy as well as wider cultural and political concerns about the impacts of fat on future generations (Lupton, 2012; Rice, 2007; 2014). Hence, even when those at a high BMI have healthy babies, questions are often raised about their capacity to parent well, with diverse sources ominously warning that fat parents will raise fat children, and in so doing, threaten the health (and fitness) of communities and nations (Friedman, 2015; Warin, Zivkovic, Moore and Davies, 2012). Amid escalating worries over the health of fat pregnant bodies and babies, few have stopped to ask how these overwhelmingly negative narratives impact those most affected—pregnant people themselves.

Despite the burgeoning studies on reproductive obesity, there is limited research investigating how weight stigma may be at least partly responsible for the risks associated with weight and pregnancy (Abenheim and Benjamin, 2011; DeJoy and Bittner, 2015). Critical health scholars argue that obesity should be regarded not as a disease, but as a “culturally produced artifact” with social effects such as discrimination against those labeled obese (Rinaldi et al., 2016: 64). A now robust literature indicates that fat stigma is entrenched in all domains of social life, including healthcare systems. As a result, some researchers have begun to consider how stigma, rather than fatness itself, may be at the root of at least some of the health effects thought to be caused by ‘excess’ weight (Budd et al., 2011; Puhl and Heuer, 2010; Wray and Dreery, 2008). This scholarship shows that risk discourses that conflate fatness with ill-health produce and/or exacerbate the health problems they ostensibly seek to prevent (McPhail et al., 2016; Rice, 2007). Weight bias—embedded as it is into healthcare spaces (small chairs and inaccessible tables and tools in doctors’ offices), technologies (ultrasound equipment that does not fit fat bodies; technologists unskilled in manual palpation of fat flesh), and provider policies, attitudes and practices—multiplies and magnifies with each recurrence. These provoke shame and stress, aggravating physical complications, blocking access to care and disincentivising help seeking in people classified as obese (Bernier and Hanson, 2012; Dolezal, 2015; Parker and Pausé, 2019; Rinaldi, Rice, Kotow and Lind, 2020). This includes fertility and pregnancy care, where stigma may play a substantive role in the negative consequences correlated with higher weight during pregnancy (Bombak, McPhail, and Ward, 2016; Parker, 2017; Ward and McPhail, 2019).

From a reproductive justice perspective, it is critical to note how anti-obesity discourses position certain populations as ‘risk populations’—including women and trans people (Rice, 2006; Rice et al., 2020), racialised and Indigenous peoples (Fee, 2006; Poudrier, 2007), and the working class/poor (Ernsberger, 2009). Although the construction of risk populations in public health and medical research is intended to bring increased attention and resources to identified groups, such focus often reproduces essentialist stereotypes about the behaviours, knowledge, intelligence and embodiments of the populations targeted (McPhail, 2013; McPhail et al., 2016; Rail and Jette, 2015), thus subjecting already marginalised people to additional stigma when their bodies are also read as fat (LaMarre et al., 2020). Weight stigma intersects with other social status markers to restrict fat people’s access to pregnancy and parenthood, often surfacing in reproductive care settings as individual blame for what are socially produced health outcomes (Ward and McPhail, 2019). Blaming the individual serves to “justif[y] the regulation and control of minority and low-income population groups as they are portrayed as the source of the ‘obesity epidemic’ and as deficient, unable, or ill-equipped to make the ‘right’ decisions in regard to their health” (Parsons et al., 2016: 603).

In this paper we feature and analyse videos created through *Reproducing Stigma: Obesity and women’s experiences of reproductive care* (hereafter *Reproducing Stigma*), a Canadian Institutes of Health Research funded research grant (PI Deborah McPhail, 2015-2018, # MOP-137019). The project used interview and video-making methods with

women-identified and trans people as well as interviews with healthcare providers and policymakers to investigate weight and other stigma in fertility and pregnancy care. We discuss how we worked with video-makers to create multimedia/digital stories in partnership with the Re•Vision Centre for Art and Social Justice at the University of Guelph, which has a mandate to use arts-informed and community-engaged research methods to foster social well-being, equity and justice. In so doing, we position this work in the context of other alternative stories—for example, Stacey Bias' *Flying While Fat* (2016) which aims to foreground first person narratives of weight stigma and travel; and the autoethnographic works of Samantha Murray and Charlotte Cooper, which offer theoretically rich, activist-oriented accounts of fat embodiment and social change (Murray, 2005, 2008; Cooper, 2016). This work thus rests within a robust feminist storytelling tradition foregrounding alternative discourses as a means of talking back to normative standards which aim to simultaneously flatten difference while hypersurveillance non-normative bodies. An attempt to operationalise this 'talking back' and to open space for listening to and learning from story in the context of health care provision (Rice, 2020) is a central tenet of *storied care*.

In the context of this project, *storied care* is explored in relation to three major themes—on risk, on recognition of weight and other stigma, and on reclamation of bodies—that emerged as critical to these storytellers as they navigated fatphobia intersecting with other marginalisations in reproductive care. We argue that just as healthcare practitioners strive to practice evidence-based care we must also put into practice *storied care*—to believe, respect and honour fat people's stories of their bodies and lives as fundamental to achieving equity and justice in reproductive healthcare.

MOVING METHODS

Reproducing Stigma was initiated to explore weight stigma in reproductive care services in Canada. We recruited participants across three provinces (Manitoba, Ontario and Quebec) using snowball sampling. In the study's Ontario site we interviewed 17 participants (15 women and two transmen) and worked intensively with nine people in Ontario to make videos. The larger study also included interviews with healthcare providers and a policy analysis. We received ethics approval for *Reproducing Stigma* through four university ethics boards, including the research ethics board at the institution from which the Ontario arm of our study was conducted, the University of Guelph. Informed consent was obtained from all research participants. For the videography project, we partnered with the Re•Vision Centre (founded and directed by Carla) to undertake the creative research iteratively by inviting researchers, artists and community members (not mutually exclusive groups) to come together to design a research process that centred marginalised, and in this case, pregnant and parenting people's, experiences, concerns and interests (Rice and Mündel, 2019, 2018). Over the past decade, the Re•Vision Centre has partnered with researchers and activists on projects experimenting with a variety of storytelling methods (video, podcasting, creative non-fiction, digital fiction and more) that explore diverse lived experiences, including disability/difference, Indigeneity and schooling, eating distress and weight stigma in queer community, aging vitalities and more (Rice, 2020; Rice et al., 2020). The choice to use digital/multimedia storytelling as an integral methodological component for this work was purposeful. Each of the authors has used this method before and we have come to understand it as a means of conveying difficult-to-understand truths, a pathway to a radically envisioned alternatives to the dominant discourses which overwhelm us. Drawing on the work of Rice and Mündel (2018: 213), we understand multimedia story-making as "knowledge producing as well as ... a critical and processual praxis for generating multiperspectival knowledges about self, other, and world." Understanding the extent to which stories have been often told about—rather than by—both fat people and parenting people (especially mothers), the choices to foreground independent voices using multi-media techniques felt essential.

Though we initially co-designed an intensive three-day workshop to support participants in creating multimedia/digital stories—short videos that use narrative, dialogue, artwork, photography, video, sound, movement and more to tell compelling stories—due to the amount of concentrated time this process required, we abandoned the workshop format in favour of a more tailored approach. Using both social media and more casual forms of recruitment, we found that stories about fertility, birth, pregnancy and parenting spanned a range of different embodiments and orientations. In the end, nine self-identified women made films, resulting in a kaleidoscope of different identities and experiences with both weight and parenthood. Importantly, both May and Emma, authors of this paper, were also filmmakers and participants in the project.

The process began with intimate one on one conversations between filmmakers and May, the first author of this article. After seeking consent, May went to people's homes, or sometimes hosted them in her home, for open-ended conversations following a series of prompts relating to weight, stigma, parenting and family. These conversations, which ranged from one to three hours, were deeply emotionally affective for both parties and often led to tears and laughter. Following these discussions, filmmakers began to develop nascent scripts following from some of the key moments or ideas that arose. A story circle was then held in May's home with all the filmmakers as well as artist-facilitators (writers, videographers, visual and performance artists) from the Re•Vision Centre.

May's role as both researcher and collaborator/filmmaker destabilised traditional modes of expertise. Through food, laughter, tears and story, filmmakers shared their fledgling scripts with one another, and both the stories and the community began to take greater shape. In the weeks and months that followed, filmmakers worked with artist supports to develop the audio and video components of the films. While the 'official' final stage was a shared screening at one of the filmmakers' home, the group has gathered multiple times since the close of the project to attend screenings and talkbacks together and many of the connections forged through the project have carried on.

In past projects each of us have undertaken multimedia story work in the context of intensive multi-day formats. For this project, it was essential that we diverged from past practice by working with each storyteller individually (rather than collectively in a group format), first to develop their narrative, and then to generate and/or source the imagery, reel, ambient sound, music and other video components that would add sensory richness and layers of meaning to the video. This was both for practical and affective reasons—parenting young children (which was the case for some participants) did not allow people to spend three or four intellectually and emotionally-intensive, immersive days creating a film (which as noted above was our initial method). These filmmakers also needed access to the kind of intimate spaces that would allow them to go to vulnerable places. As a result, the videos were created in and around people's home spaces; and dinner tables, kitchens, bedrooms, bathrooms, playgrounds, streets, local markets and other everyday scenes figure prominently in the final work that storytellers created. By all accounts, the process was deeply emotional and transformative for the researchers and storytellers alike. Importantly, key moments in the process—story circle and screening—allowed the group to come together so that community remained foregrounded despite individualising the methodology.

Each of us came to this project with our own histories of weight stigma and interests in the possibilities (and limits) of storytelling to intervene in received accounts. Given that some research team members (including May and Emma) made videos, and many research participants co-present videos at events and co-write articles (Carla) we use the term 'researcher-participants' in recognition of this deep and on-going boundary-crossing collaboration. Importantly, the informed consent offered to researcher-participants has allowed for flexibility in the dissemination of the videos. Some researcher-participants have preferred that their films remain private or only shown at public screenings, while others allow for full access for conference presentations or publications. All films referenced here are presented and analysed with written and verbal consent from the video-makers.

As researchers (and two of us as participants), we are acutely aware of how our positionalities shape our attachments to this research and offer our embodied reflections as a way to situate ourselves in the work we present and analyse. I, May, have come to think through weight and story from a number of lenses: I worked for several years as a social worker in community health centres where weight was a frequent topic of discussion; now I research fatness through a range of methods and intersections, including through people's lived experiences using arts-based methods and by undertaking discourse analyses of popular culture. I also think about fat through my own life: as a racialised woman, as an aging woman and as a parent to young people with their own complex and dynamic relationships to weight. The thread that has wound through my diverse academic interests has been a commitment to story. Using arts-based methods to critically create, explore and examine stories has been a natural extension of my passion for embodied and critically informed research.

I, Carla, have been committed to storywork for a long time. In a previous life as a fat activist and clinician at a women's health care centre, I worked with my own and others' stories of food and weight distress and used narrative methods (White, 2007) to support fat communities in recognising our agency and creativity, and in rewriting those stories. Later my doctoral research examined a rich sampling of women's body his-stories and how these entangled with larger cultural narratives told about their bodies (Rice, 2014). While storytelling has been integral to my work, I have long wanted to move stories told from the margins—from the privatised, commodified and instrumentalised spaces of therapy and interview rooms—into the centre, to breathe new life into and transform the public sphere. Through storytelling projects such as *Reproducing Stigma*, I have found a way to undertake that work.

I, Emma, have been studying stories and power for the last twenty years as a student, teacher and researcher. I began studying feminist theory in order to understand my own life story and my relationship to power. It was in the awkward, tongue-tied, socially anxious moments of not knowing what to say about race that I began to focus my research on the limits of personal narrative, particularly the limitations of relying on self-awareness when it comes to white privilege and white anti-racism. My research has focused on ways of telling stories about racism that involve objects (like home decorating) and space (like the design of neighbourhoods) rather than personal reflection, because my experience of stories is that some get told easier than others. This project presented an opportunity for me to further examine the silences we share and how they can be unpacked in order to generate meaning.

As scholars of embodiment, of story, of diversity and non/normativity, we come to these films with a range of intellectual orientations. We also come to them with a great deal of heart. We would argue that these films are impossible to understand with mere intellect, and that, in fact, their power rests in their capacity to marry heart

and mind through simultaneous affective and cognitive engagement. It is with these tools in mind, then, that we turn to the key themes which emerged from this work.

ON RISK

The Oxford English Dictionary defines risk as the “possibility of harm” (‘Risk’ 2010), but its linguistic roots are broader than that. Risk is derived from the French *risque*, which means danger, or inconvenience. A secondary meaning of the word risk is the possibility of lost profit. This secondary meaning relates to the kind of financial loss that somebody can be insured against. The etymology of risk’s relationship to insurance against financial loss comes from its medieval use, when it meant the possibility of damage to merchandise transported by sea. Risk was a way of maintaining profit margins when navigating unforeseen stormy waters. Risk acknowledges the uncertainty, the unpredictability and the dangers of the unknown but nonetheless tries to trick us into thinking we can buy insurance against our worst fears: that somehow, profit can happen whether or not the sea cooperates. And deeper than that, risk invites us to imagine that if unforeseen disaster strikes, that someone must bear the costs of blame.

Being labelled ‘high-risk’ serves some helpful functions, such as triggering different clinical guidelines to better care for a patient, but the high-risk label also does imaginative work. The idea of a high-risk patient distinguishes the high-risk body from a body imagined to be normal. And the imaginative work of normalising some bodies, and characterising others as risky, creates a logic where mitigating risks means trying to transform a risky body into a normal body. Emma’s digital story, *Born, Still*, describes the emotional impact that being labelled high-risk had on her as a patient. *Born, Still* illustrates how the attempts to mitigate risks through forced weight loss cause significant emotional harm.

Emma’s film chronicles her experience of disaster (<https://revisioncentre.ca/high-risk-body>; password ‘reproducing stigma’). In April of 2017, Emma, a ‘high-risk’ pregnant woman, gave birth to a stillborn son named Christopher. Through weight loss and gain, she has never occupied a weight category labelled ‘normal’. Emma’s story narrates her process of conceiving, knowing that high-risk pregnancy was the only kind of pregnancy her body would be capable of having, carrying to term and at 41 weeks gestation, experiencing the devastation of learning that her son had lost his heartbeat. Emma knew that she was a high-risk pregnant woman, as did her care providers. All the clinical guidelines were followed, and still, there was no stopping the storm from coming.

The imaginative work of changing bodies to mitigate risks is rooted in what we believe can change. If high body mass is a risk, and we believe that it is caused by human actions, rather than human existence, then blame for the risk can be offloaded onto the patient in a way that would be unimaginable for other risk factors. For instance, there are risks an 80-year-old patient would face during surgery that differ from those faced by a 25-year-old, but it would be nonsensical to suggest that an 80-year-old should somehow become 25 in order to limit risk. Weight stigma that circulates in our society imagines weight to be something that can be lost. This idea persists despite strong evidence suggesting that only modest amounts of weight can be lost with significant lifestyle changes. In other words, to expect a fat body to become thin is as nonsensical as expecting a body to reduce its age (Gard and Wright, 2005; Campos, 2004; Bacon, 2010). In Emma’s case, a modest amount of weight loss would still place her within the category of ‘class III obesity’. A high-risk body is the only body she is likely to ever inhabit.

The discursive discouraging of fat bodies from planning pregnancy has been referred to by critical health researchers as a form of “soft” eugenics (McPhail et al., 2016: 101; see also Bombak, McPhail and Ward, 2016; Cain, 2013; Ward and McPhail, 2019). Conversely, the midwife’s insistence that Emma’s body birthed well provided a counter-narrative for her to use as she healed from the birth and began considering options for future pregnancy. The care that the midwife provided—what we are calling *storied care*—was de-stigmatising in its centring of listening and learning from embodied experience, and consequently, offered tools for healing. As a result of the conversation with the midwife, Emma could begin to story her body as a strong and powerful body that survived something tragic, rather than a guilty, risky body responsible for ushering in inevitable loss.

Marcia’s film, *Untitled*, models an interpretive framework for understanding risk as embedded within complex webs of relationships (<https://revisioncentre.ca/high-risk-body>; password ‘reproducing stigma’). Marcia asks, “Where does one thing end and another begin?” Her story reminds us that risk is about making calculated estimations. In Marcia’s story, the possible side-effects of pre-eclampsia drugs were weighed against the risk of maternal or fetal demise. Marcia invites us to consider the many possible ways that outcomes can be interpreted, inviting a consideration of risk that is not clear or well defined but instead acknowledges the overlap between categories of health and dis/ease, risk and safety, clarity and ambiguity.

Marcia’s film focuses on distinctions, and in her exploration of distinctions, she leads viewers towards interpretation. Interpretive training is costly and inconvenient for doctors to seek out. We expect doctors to be the experts in diagnostics. To diagnose means to distinguish, to recognise and to identify. Diagnostic labour distinguishes some symptoms from others and identifies the presence of disease. However, when identifying the

presence of risk, sometimes what gets identified is not risk, but rather the blame for the risk itself. The stories we tell about risks implicitly assign blame for the risk, rather than an interpretive framework for navigating risk factors.

As we have mentioned, risk is derived from words meaning danger, inconvenience and a loss of profit. If we think of a high-risk body as an inconvenient body, we begin to see the boundaries of risk's meaning. Convenience is about predictability, patterns, standards and the ways we can make things uniform in their sequencing and design; so much of our work lives and workplaces rely on standardised design. We invite readers to cultivate a suspicion of risk, and whose interests it seeks to protect. Rather than understanding risk as evidence of impending disaster, we invite readers to consider risk as evidence of unforeseeable need. Could risk be minimised by changing not the patient's body, but instead the system that cares for them?

We invite a reconsideration of high-risk patients as unprofitable bodies to the system designed to treat them. High-risk patients may cost more money, take more time, be inconvenient. In short: their presence and the confusion they create may break the rules of the workplace. High-risk patients are not patients who can conveniently slip into standardised metrics of care, nor standardised hospital gowns. High-risk patients require a different skill set, one that involves less certainty, and more interpretation. Knowing the risks is only part of what is required of practitioners. High-risk patients present opportunities not just for the application of protocol, but for the practitioner to translate the guideline onto the individualised context of the patient's experience. The labour that is required to do this is interpretive labour, and it may arguably improve care for patients at all levels of risk.

ON RECOGNITION

As the section above outlines, discourses of risk construct narratives of 'broken' or costly bodies that are in need of fixing. These discourses have a huge impact on service users in all areas of medicine and social service (Friedman, 2012), and these impacts are heightened in the unique vulnerabilities that take place around fertility and reproduction. If a risk lens is problematic, what alternatives exist to ensure respectful and effective care? The films discussed here provide interesting responses to this question. Specifically, the films centre ideas about recognition.

This recognition manifested in a range of ways: in both the process of creating the films, which allowed for conversations (about weight stigma and its myriad intersections) that are often cast outside the mainstream, but also about specific moments of recognition—or sometimes, its absence—in care relationships.

Filmmakers talked about the process of filmmaking allowing them to be deeply seen, casting light on parts of themselves and their journeys that had been, for the most part, ignored. At the culminating screening for the project, the group collectively gasped, laughed and cried at the truths that resonated from one other's stories, and this recognition has carried through into public screenings in which members of the audience have responded viscerally to the films and have conveyed, in a range of ways, the extent to which these narratives allow viewers to feel seen.

The shift toward trusting oneself, toward an internalised recognition, was an unexpected byproduct of this project. Filmmakers wanted audiences to see them differently, but in the process of filmmaking often came to recognise themselves more completely or differently than they had done previously. Many of the participants came to this project because they were ready to question the taken-for-granted assumptions about fat bodies as dangerous or unworthy (Wann, 2009). In the midst of ubiquitous messaging that equates fat with risk, this project allowed filmmakers to begin to consider alternative interpretations of their bodies and experiences. The filmmakers separately and collectively began to question issues of responsibility, compliance and blame and the ways that fat may be meaningful (beyond its literal impact) because of the *discursive* impact of fatness, the layers of messaging that fatness puts upon bodies (LeBesco, 2010; McPhail, Brady and Gingras, 2016). Filmmakers also shifted in understanding fatness as a normal distinction like height: so, for example, meaningful in the moment of considering which chair to sit in or thinking about which shoes to put on to protect hard working joints, but not necessarily pathological (Bacon and Aphramor, 2011; Paradis, Kuper and Resnick, 2013). Recognition allowed participants to view fat bodies as potentially requiring different interventions, rather than assuming that fat people are required to change.

The process of making the films exposed a need for recognition that was surprising, even to the research team. Specifically, it became clear through the process of the creation of scripts and films that people—of all sizes and shapes—were absolutely starving to discuss their relationship to weight and their bodies. Several filmmakers commented that the initial story circle (which led to the eventual creation of the films) was the first time they had ever discussed the impact of weight stigma, despite its central presence in their lives.

Filmmakers also saw fertility and reproduction as uniquely vulnerable life moments and considered the cumulative impact of shame in fatphobic expressions toward people who are pregnant or are attempting to become pregnant (LaMarre et al., 2020). The impact of recognition, and the cost of its absence in reproductive contexts, are amply displayed in May's story, *Too Much* (<https://revisioncentre.ca/high-risk-body>; password 'reproducing stigma'). This film considers the complex intersections of weight, race, fertility and reproduction and, like all the

films in this project, does not conclusively determine the body as either a source of celebration or failure. Rather, this film considers the ways that weight and weight stigma are dynamic and overwhelming, especially as understood in the context of fertility and reproduction. Importantly, however, this film also considers the impact of recognition from service providers by contrasting two very different moments of care. In the first, the film details cavalier treatment on the part of a fertility specialist and his medical student who ignore May's lived experiences and embodied expertise in favour of 'empirical' and data driven conclusions that were simultaneously erroneous and disrespectful. In contrast, the film explores a conversation that takes place during labour between May and her midwife, who gently asks her what is impeding her ability to birth her baby, triggering both emotional and physical responses that allow labour to successfully proceed. The film thus tacitly centres recognition as imperative to caregiving relationships, especially around fraught issues like weight, and in the vulnerabilities of fertility and reproductive care.

Ideas about recognition are manifest in anti-oppressive literature about care work (Massaquoi, 2017; Brown, 2017). As yet, however, the impact of a practice of recognition has been largely minimised in relation to fatphobia, despite the pernicious and dangerous impacts of fat phobia on health care (Chrisler and Barney, 2016; Puhl and Brownell, 2006). The films in this project cast light on what might be required in order to successfully inject ideas of recognition into reproductive health care contexts.

Discourses of fatphobia cannot be understood without simultaneously acknowledging structures such as poverty, racism, homophobia and transphobia, and mother-blame, as well as the internationalisation of these discourses (Friedman, Rice and Rinaldi, 2020). For example, *Fear, Fat, Food and Failure: Feminist ruminations on birthing* (<https://revisioncentre.ca/high-risk-body>; password 'reproducing stigma') explicitly considers the intersections of weight stigma, poverty, mental health and the complicated push/pull of family relationships. The filmmaker, Kelly, herself an academic and care provider, asks viewers to consider the complexities of origin stories and the need to remain attuned to the many layers of ambiguity and emotion that lead to our present day bodies and lives. Kelly's experience of health and health care cannot be understood or recognised without acknowledgement of her intersections as well as her experiences in both her family of origin and the family she has created and lives in now. Such an intersectional analysis must begin by centering social justice (Rice, Harrison and Friedman, 2019). In the context of Kelly's film, an analysis of her health that fails to consider the structural context of her environment would be ineffective, shaming and potentially medically dangerous in its limited view. By contrast, a framework that imbeds the type of recognition that is evident in this short film would allow for an expansive analysis of Kelly's relationship to weight and health that would allow for care that is both affirming and comprehensive.

Fat studies scholars have discussed the ways that medical professionals may make assumptions about health based on visual assessments of patients' size (Tomiya et al., 2016). However, this project exposed a different finding: that the ubiquitous and enormous impact of thinking and strategising about weight is potentially *underrecognised* in medical care, to the great detriment of patients and clinicians alike. As such, these films suggest that care providers should take up issues of weight both *more* and *less* seriously—more seriously, in terms of thinking of the impact of weight avoidance and fatphobia on service users, but less seriously in terms of pathologising risk. Importantly, this pivot requires listening to people's stories of their bodies and lives as a precondition for providing effective care.

If the films encourage a move away from discourses of risk and toward an embedding of recognition, what does this actually mean for service providers in practice? The films exposed the ways that details of patients' lived experiences may elude even skilled practitioners. Shifting to a care paradigm of recognition would expose some of these gaps. For example, exposing that some fat patients only travel by taxi because public transport may put them at risk of verbal and physical abuse; that some allegedly 'normal' bodies may not reveal complicated engagements with weight; that being weighed—for all kinds of bodies—is virtually never a benign exercise in data collection but may feel like an act of violence.

A paradigm of recognition requires that service providers acknowledge that fatphobia, like all stigma, has its own health effects (Puhl and Brownell, 2006; Thille, Friedman and Setchell, 2017). Experiencing hatred and violence in daily interactions, limitations on employment, housing, educational and relationship opportunities, constant assumptions that fat people are lazy, unhealthy, ugly and vile—these impacts come at a cost to health (Chrisler and Barney, 2016), as do internalised weight stigma and fat phobia. Thinking through these internalised messages further emphasises the need for recognition, and for medical care to respect self-recognition and client expertise and—even more radically—to encourage service users to trust their own instincts.

The films' centering of fat, its presence, the cost of attempts to avoid it, and, relatedly, complicated and often disordered relationships with food and exercise equally present an ongoing discussion on the heavy silence around these topics in health care interactions, and in virtually all spaces outside of fat activist forums. Filmmakers asked for acknowledgement of the ways that many had been told to lose weight in virtually every medical interaction of their lives, while other, thinner, participants revealed the ways that their relationship with weight was sometimes dismissed in medical settings despite complicated histories with food restriction. While it is imperative that we

acknowledge that the specificities of the lack of recognition of weight and weight stigma vary considerably across social contexts and categories, this project exposed the extent to which there are complexities that people are aching to reveal, with regard to food, fat, fitness and the spaces between and beyond.

ON RECLAMATION

The stories we have analysed thus far dramatise many intense emotional and physical challenges that come with reproductivity and with being sexed female—whether self-identified or assigned—in the contemporary postfeminist moment. According to cultural studies scholar Rosalind Gill (2007; 2017), a postfeminist sensibility has come to permeate western popular culture as a new form of sexism emerging from neoliberal capitalism and its influence on ideals of femininity and gendered subjectivity more generally. Under postfeminism, neo-liberal values of hyper-individuality and self-determination that permeate marketing and popular media co-opt and commodify feminist scripts of empowerment by convincing women to find freedom and choice through their purchasing power. This is achieved especially through self and bodywork, which is framed as the ultimate pathway to success and self-actualisation (Riley et al., 2017). In their negotiation of postfeminist values, the filmmakers move beyond themes of fertility and pregnancy, telling stories of body and food-related struggles that many of us, whether we identify wholly or partially as women, as mothers, as parents and as caregivers, carry about our bodies, our sense of ourselves, our images and our appetites in postfeminist times. Though they tell stories of body-based struggle and striving, they also story tender moments: moments of affirmation, moments of care, moments of love. Their stories demonstrate how a person’s sense of embodiment—or body image, if you will—is neither static nor wholly determined by discourse or culture. Rather, our body images shift and change in subtle and substantive ways as we move through time and space, changing along with the physical changes we undertake/undergo, and with changes in our cultural, social, spatial, material and relational worlds.

Consistent with this approach, feminist constructionist psychologists Kate Gleeson and Hannah Frith (2006: 79) argue for rethinking the concept of ‘body image’ along more processual lines, such as body *imaging*—as a verb rather than a noun, “an activity rather than a product,” or, something a person does rather than as something they have or are. It is also why new materialist scholar Carla Rice (2014) proposes a becoming theory of body imaging, which posits how mind, body and world—understood as non-divisible forces—continuously intra-act to co-constitute our embodied existence. Unlike conventional body image research that approaches these as separable and measurable ‘factors’ in constructing our imagined sense of body, Rice argues that body images form and transform through the interactions of physical bodies, psyches, and worlds. These forces, like the construct of body image itself, “have no nature or facticity that can be discovered prior to their becoming-in-relation”, and hence cannot be compartmentalised into separable factors or variables in the ways that mainstream theories presume (2018: 557).

Feminist reconceptualisations of body image as a construct continuously forming and trans-forming through the confrontation of matter (our bodies and physical environments) with meaning (our psyches and sociocultural contexts) suggests that while powerful physical and social forces act on us, we also exercise power in shaping our body and self-images. Despite confronting body-related struggles and stigmas, storytellers re-story their bodily selves by offering up narratives of reclamation. But what does it mean for someone to reclaim one’s body, especially after emotionally and physically intensive and life changing events, including pregnancy and childbirth? We might begin to unpack this question by recognising how the idea of reclamation differs from that of resolution. According to standard dictionary definitions, resolution denotes firmness of purpose; one’s determination of a certain course of action; and the settling of a problem. In healthcare, it typically refers to the return from a pathological to a normative condition—in other words, to fixing or cure. Disability studies has much to say about what feminist disability studies scholar Alison Kafer (2013: 27) calls “the curative imaginary”. According to Kafer, in offering the seductive promise of cure, the curative imaginary works against mindbody differences of all kinds, including fat embodiments, by funnelling resources and energies into biomedical research that aims to normalise bodies and move away from the urgent need to accept bodily difference by creating a more accessible world in the here and now. Further, in promising a “future perfect” (Rice et al., 2017: 217), the curative imaginary offers up visions of a future which is just out of grasp but which in reality, is ever deferred since cure (whether technological, pharmacological or surgical) can never fully eradicate difference and since any project that seeks to eradicate embodied difference entirely, is, at its core, ableist and fatphobic.

Reclamation, in contrast, denotes the recovery of that which was harmed or hurt (a recognition that something has been taken); a return, or more provocatively still, a turn to a generative, lively and vital state of being. Reclamation thus differs from resolution in offering a pathway to recuperation and regeneration *without* requiring the attainment of a problem-free state. This is a critically important shift in thinking that gives us a glimpse to what over-determined concepts like recovery, wellbeing, and health might mean if we attend closely to story and listen

deeply to the ways people regularly re-signify these terms beyond their individualised, homogenised and medicalised meanings.

These themes are resonant in Claudia's *Nurturing*, a story of the emotional and social complexities of her conflicted relationships with food (<https://revisioncentre.ca/high-risk-body>; password 'reproducing stigma'). Appetite never signifies physical hunger alone—it is entangled with care for others and denial of the self, with the violence done by others and enacted against herself, and with the struggle to find balance in the giving and receiving of all that is required for living. The film's reclamation is found in the simple symmetry of the place setting, which perhaps works as a metaphor for Claudia's hunger to find a place that is nourishing, satisfying and satiating in the world.

The stories seen here illuminate how people can and do fail to resolve difficult life challenges and psychic wounds and bruises (and perhaps inevitably so given the extent to which these are socially produced) while still celebrating the material and spiritual joys of living and creating in response to them. For us, this resonates with Black feminist writer Audre Lorde's self-described 'biomythography', *Zami: A New Spelling of My Name* (1982). Lorde's reconfiguration of life writing artfully weaves together biography, history and imagination, and in so doing, opens space for her to tell her differences and myriad selves. Like Lorde, Claudia and other video-makers recount traumatic memories and the effects of these on their bodily selves even as they foreground sensuous, empowering experiences. They remind us of the importance of pleasure and connection to the reclamation of embodiment and difference. We call this micro-recognition. Critical disability scholar Arseli Dokumaci (2017) calls it 'micro-affordances'—the everyday actions that people who embody difference instigate to bend and shift discourses and environments to fit our bodies. Drawing on new materialist thought, Dokumaci argues that micro-affordances are "activist in the sense that they are 'potentially transformative actions in the world', and they are micro in reference to their scale and fleetingness" (404).

The videos re-story embodiment as process, exploring the body's metamorphosis and the storytellers' inhabiting and imagining of its constant movement and change in ways that refuse finality or closure. Neither Claudia nor Sophie, referenced below, fully resolve their struggles with food or body, but both gesture toward the idea that it is possible to find acceptance, and even joy, through dwelling affirmatively in the contradictions. Reflecting on the videos, we assert that micro-recognitions and micro-affordances are precisely what enable the reclamation of what Anh Hua (2015: 113) calls the "female embodiment, pleasure, and sensuality as an activist sacred site to counter the patriarchal, racialized, and heteronormative [as well as ableist and sizeist] oppressions that so many women experience in our daily lives".

We end with Sophie's *Covenant*, (<https://revisioncentre.ca/high-risk-body>; password 'reproducing stigma'), a story of the emotional and social complexities of body lessons, spoken and unspoken, that mothers pass onto their daughters and women onto others in their lives—lessons about looking and being looking at, about femininity and beauty, about power and difference, about failure, fat and food. The film's reclamation is found through a commitment—a promise that Sophie's mother makes and that Sophie, in turn, bequeaths to her daughters. This is what she names the 'sacred covenant' she enters into with her daughters, with us as witnesses, made not so much to secure their futures but to scaffold micro-relations—recognitions and affordances—freed of the cultural gaze.

CONCLUSION

While our scholarship has been about the specificities of weight stigma, the insights we've gathered have applicability in thinking about non-normative bodies more broadly, and about the power of stories specifically. This work requires a shift in understanding that acknowledges lived experience as a form of theory. Such an understanding is politically and socially important and represents a deeply anti-colonial way of thinking. Enlightenment knowledge asks us to consider empirical measures as the most important ways of knowing. Researchers and practitioners test, measure, weigh, and from there, plan. We invite readers to query this understanding, in part by drawing from Indigenous knowledge in suggesting that story itself can be fact, research, data. We offer these films not as primary artifacts put forth for analysis, but rather as deep research in their own right.

We argue that the pendulum has swung too far toward prioritising numeric data and scientific precision and away from the storied expertise of personal experience. This presents multiple concerns. Firstly, scientific precision has always been informed by structural and social theories, including eugenic theories that 'confirmed' Black bodies were supposedly inferior to white bodies, and that homosexuals were deviant. We suggest that an uncritical deferral to scientific expertise is potentially limited and fraught. Secondly, a wholesale engagement with numeric data omits meaningful details, and, as a result, *cannot* result in good research or, subsequently, good care. This research conveys this point in relation to treatment of fat people, but also holds true for treatment of a range of non-normative or unruly embodiments and mentalities. We therefore offer this analysis of fatphobia in reproductive care as a case

study but suggest that critical thinking through complex ideas of risk, recognition and reclamation might be necessary in order to shift toward more ethical and meaningful forms of research and practice for all people.

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