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Reproducing Fat-Phobia

Reproductive Technologies and Fat Women's Right to Mother

In September 2011, doctors from the Canadian Fertility and Andrology Society met to discuss the need for a clear policy denying IVF and other forms of assisted reproductive technology to women who have a BMI in the "obese" category (Abraham). While the debate did not result in a final policy for the Society, the dialogue stemmed from the fact that many Canadian clinics have already instituted such policies independently. Likewise, many other jurisdictions continue to institute similar policies of denying reproductive technologies to women who are viewed as overly large. This paper aims to discuss the specific challenges faced by fat people attempting to build family in non-normative ways. Specifically, by looking at the implications for fat bodies requiring reproductive assistance as well as fat people looking to build family through adoption, I aim to unpack some of the ways that fat people are intrinsically viewed as unworthy of parenting. This is especially true for fat women with intersecting identities such as race and class that immediately position them outside of the realm of "good motherhood." This article aims to critically respond to the growing trend of discrimination and explores the underlying messages about maternity, reproduction, and fat that underpin attempts to stem fat women's paths to family.

Introduction

In September 2011, doctors from the Canadian Fertility and Andrology Society met to discuss the need for a clear policy denying IVF and other forms of assisted reproductive technology to women who have a BMI in the "obese" category (Abraham). While the debate did not result in a final policy for the Society, the dialogue stemmed from the fact that many Canadian clinics have already instituted such policies independently. Likewise, many other jurisdictions

continue to institute similar policies of denying reproductive technologies to women who are viewed as overly large.

These policies can be situated in a broader context of weight discrimination occurring in virtually all areas of life: from bullying in the schoolyard, through employment and housing related discrimination, denial of health insurance, and discriminatory treatment from healthcare providers (Wann). Fat people are less likely to be hired or promoted, and experience discrimination at every level of the education system (Puhl and Brownell). The "cradle to grave" implications of weight discrimination affect every part of a person's life. This paper aims to discuss the specific challenges faced by fat people attempted to build family in non-normative ways. By examining the trends in access for fat bodies requiring reproductive assistance as well as fat people looking to build family through adoption, I aim to unpack some of the ways that fat people are intrinsically viewed as unworthy of parenting. This article examines the limited scholarship on fat and reproductive access and policies around fat and adoption by drawing on the discursive construction of fat bodies and the ways such discourses step toward and away from motherhood. Furthermore, I will consider the ways that fat women with intersecting identities such as race and class may be immediately positioned outside of the realm of "good motherhood." This article aims to critically respond to the growing trend of discrimination and explores the underlying messages about maternity, reproduction, and fat that underpin attempts to stem fat women's paths to family.

Your Mama's So Fat…

The shifts in public discourse that penalize fat would-be mothers are part of a larger context that positions fat people as unworthy, dangerous and lazy (Wann; Puhl and Brownell; Collier; LeBesco and Evans Braziel). While there are acute effects of this stigma in many realms, it is important to consider the implications for fat women who are already parents before looking at *potential* mothers in more detail. Despite the many barriers to family-building that fat women may face, many fat women do become mothers. These mothers face heightened scrutiny and criticism as mothers who do not fit normative ideals (Herndon; Zivkovic et al.). Fat, as a socially constructed category, is also intersected by other sites of identity. It is important, then, to recall that the virulent impacts of fatness are differentially experienced by mothers of different races, classes, abilities, sexual and gender orientations, ages, and beyond.

Fat mothers are scrutinized during pregnancy, told to gain less or even lose weight while pregnant, regardless of nausea, discomfort or other nutritional requirements of pregnancy. Fat mothers are seen as inactive and lazy (Zivkovic

et al.) and are thus held to an even higher account when choosing, for whatever reasons, not to run after their kids or sit on the floor playing with Lego for the fourteenth hour of the day. Fat mothers may be even more scrutinized than their skinny counterparts when it comes to food related parenting, including providing nutritious meals (Herndon; Zivkovic et al.). Anyone who has ever parented a toddler who refuses to eat anything that isn't beige can relate to the anxiety of trying to provide healthy options to picky small people—that anxiety may be increased for mothers who are visibly marked as unconcerned about nutrition. (Like so many common sense notions about fat people, the myth of fat people's ignorance of nutrtition is just that—a myth—especially since fat people, especially women, are likelier to have been lectured about nutrition constantly.) Mothers who are poor and fat, or fat mothers with disabilities may have even fewer choices with respect to nutrition and exercise, but their different capacity will not protect them from censure.

The stigma and scrutiny of fat mothers becomes even more pronounced for fat mothers of fat children. There have now been multiple instances of child welfare seizing children whose parents have not successfully made them thin (Friedman, M. 2015). In one instance in Scotland, parents were court mandated to put their large son and daughter into sports and dance classes, respectively, suggesting that these seizures may be about reproducing norms, in terms of both gender and body types, rather than maintaining health ("Your children are too fat"). April Herndon suggests that "The rhetoric used to make and bolster claims about mothers and children and the childhood obesity epidemic appears ripe for co-optation by those who seem to have as much, if not more, investment in defining women's roles, creating nostalgia for bygone eras, and pushing forward political agendas as they have concern over children's wellbeing" (333). These discourses have specific virulent implications for fat mothers who are otherwise marginalized due to their sexual or gender orientation, race, age, or other social location.

A quick look at the reality TV phenomenon, *Here Comes Honey Boo Boo* reveals both the extent to which the "fat mama" is simultaneously the butt of a joke as well as viewed as uncouth, hygienically impaired and generally coarse. The presentations of poverty in *Honey Boo Boo* are blended with the family's oversized presence to position the whole family, but especially mother June, as uncomfortably laughable. June's obvious love for, and commitment to, her children is sidelined by the constant footage of her eating, burping and farting (Friedman, M. 2014), intercut with shots of the cheap food and the railroad track which abuts the family home. Fat, poor mothers like June live outside the romanticized pink "What To Expect" version of maternity. What are fat women to do to transcend this lack of fit, this uncomfortable mismatch between myth and reality in order to become mothers in the first place? And

how is the increasing moral panic about obesity used to bludgeon and control fat people, in particular fat mothers?

When Fat Isn't Mama

Before looking at fat women who build family in non-traditional ways, it is important to remember that many fat women, like June, and like me, *do* become pregnant under the usual conditions. Given the huge number of people characterized as either overweight or obese (62 percent in Canada [Employment and Social Development Canada]; 69 percent in the United States [Centers for Disease Control 2013], it is obvious that many fat women are reproducing. The high number of fat people in North American also begs the question of terminology: "over" which "weight"? These words make clear both the inefficacy and judgment centred in words like "overweight" and "obese."[1] Nonetheless, organizing bodies such as the Canadian Fertility and Andrology Society aim to deny reproductive treatment to women who are in the categories of "obese" or "very obese." By way of reference, this implies that a woman who weighs 175 lbs. and stands 5' 4" tall would be turned away from treatment (Women's Health).

I would be one of the people turned away from treatment if I weren't privileged enough to have gotten pregnant without intervention. This privilege is not merely about biological fertility. If I were partnered with a woman and intended to gestate, or chose single motherhood, or if I were partnered with a person with fertility issues, in each of those instances I might have sought the care of reproductive medicine. And in each of those instances, independent of my own fertility, I would have been denied. In my own case, that would have been a grave error, since I have shown myself to be someone who gets pregnant fairly easily. Yet if I crossed the threshold of many fertility clinics, I would be told to return only after losing 50 pounds or more.

These guidelines are not evidence that Canadians are uniquely hostile to fat people. Similar guidelines are in place in the United Kingdom and New Zealand (Abraham). And while no final national conclusion was made in the Canadian case, individual Canadian clinics are free to set their own guidelines. In general, because in almost all jurisdictions, fertility treatments are outside of national health insurance (and also many supplementary insurance plans) they are also uniquely ungoverned, so fat women who are discriminated against have no recourse. This is especially true because few jurisdictions explicitly name weight discrimination as a protected category. For example, in Canada, there is no protection on the basis of size in the Charter of Rights and Freedoms, while only two U.S. states name weight as a protected category (Coller; DeVries).

Fat Myths

The argument toward denying reproductive treatment to fat women rests on deeply held beliefs that discipline fat bodies: that fat is borne of personal choice, that fat is unhealthy, and, in the case of reproductive technologies, that fat women are less likely to achieve and sustain pregnancies when treated. While all of these ideas have achieved the level of common sense truths due to their ubiquity (at least in Western jurisdictions and in the contemporary era), they are nonetheless contentious. First: the idea that fat is chosen is heavily disputed. Molecular geneticist Jeffrey Friedman writes that,

> The heritability of obesity is equivalent to that of height and greater than that of almost every other condition that has been studied—greater than for schizophrenia, greater than for breast cancer, greater than for heart disease and so on. Although environmental factors contribute to changes in the incidence of obesity over time, individual differences in weight are largely attributable to genetic factors. (563)

Even mainstream medical scholarship concedes that obesity is multifactorial and thus caused by an alchemy of physical, social and societal influences. Furthermore, there is considerable evidence that diets inevitably fail. Virtually all studies that look at long term (over five year) weight loss find that in 95 percent of cases, bodies return to their starting weight or higher (Bacon and Aphramor; Gaesser 2009). If, in fact, fat women are less responsive to reproductive treatments (a finding which is itself in dispute), requiring weight loss to enter treatment is not a realistic outcome. Nonetheless, clinics in many Western nations and Primary Health trusts in the U.K. continue to limit access to obese women. As Anna Smajdor writes, "Considerations such as … BMI hover uneasily on the border between social and medical criteria. The inclusion of such factors by [Primary Care Trusts] seems to introduce a punitive element into the evaluation: does the patient deserve treatment? Has she made foolish, irresponsible or immoral choices?" (n.p). The requirement of weight loss to even attempt fertility treatments reinforces deeply held beliefs about both fat and infertile bodies as unfeminine and sites of "broken" womanhood.

The relationship between fat and ill health is likewise not as robust as popular culture would suggest. Fat people experience intense medical discrimination and poor or no medical treatment, which may contribute to at least some of the findings of fat people who have poorer health outcomes (Puhl and Brownell; Brochu and Esses). Furthermore, some of the health conditions which are prevalent in fat bodies may be correlative rather than causal—in other words,

perhaps the same genetic algorithm is responsible for both fatness and hypertension, rather than fatness itself being responsible (Wann; Flegal). Much research begins from a bias that fat bodies are intrinsically unhealthy, and this bias has an impact on research design; the prevalence of medical research funded by pharmacological and weight loss industries likewise suggests that the indubitable impact of fat on health should be viewed with suspicion (Wann; Gaesser 2002). Finally, studies that look at diet and fitness—independent of body size and composition—tend to find that health outcomes are evenly distributed across all body types who engage in similar activities (Bacon and Aphramor). In light of this finding, the fat stigma that keeps many fat people from discovering joyful movement might provide an alternate explanation for health concerns related to sedentary lifestyles. Despite the overwhelming rhetoric about the obesity "epidemic," in 2007 the American Centers for Disease Control stated that, "Obesity prevalence has not measurably increased in the last few years." ("New CDC Study Finds no Increase in Obesity Among Adults" n.p.).[2] Supporting the view that it is rhetoric, rather than weight, which is increasing, Marilyn Wann argues that,

> During the last quarter century, while Americans have gained on average twenty or so pounds, the mainstream media has gone from mentioning the term 'obesity' only sixty times per year in the early 1980s to five hundred times per year in 1990, to one thousand mentions in 1995, three thousand mentions in 2000 and seven thousand panic-stricken mentions of "obesity" in 2003. (xvi-xvii)

Indeed, the social construction of fat and thin is notoriously fluid, both historically and across geographic boundaries. Concerns about the healthiness of fat bodies are suspiciously parallel to the aesthetic mores of particular times and places, suggesting that concerns about health are standing in for pronouncements about the ways bodies should look. The social construction of fatness lends itself well to using fat as a way to police bodies through discourses of health and self-control, rather than examining intrinsically subjective beliefs about the aesthetics of female beauty and appropriate conventions of motherhood. These conventions are also deeply rooted in the beauty conventions of fat and race.

Given the confusion about who is fat and who ought to mother, the inconsistencies in research about fat women and reproductive technologies are hardly surprising (Maheshwari et al.). The official recommendation by the British Fertility Society Policy and Practice Guidelines suggest that all women "aim for a normal BMI before starting any type of fertility treatment" (Balen and Anderson 195); this suggestion is echoed by Vasiliki Moragianni, Stephanie Marie Jones and David Ryley who say that "Obesity has a significant negative

effect on [Artificial Reproductive Technology] outcomes" (102). By contrast, however, another study concludes that "Obese patients undergoing IVF are more likely to undergo cancellation. If cancellation does not occur, obesity confers a risk of a lower stimulation response. *Despite this, the clinical pregnancy rates (per retrieval) were no different in obese patients and nonobese patients*" (Spandorfer et al, emphasis added). Yet a third study suggests that while fat women might require different medication protocols, "IVF outcome is not effected by an increased BMI" (Dechaud et al. 91).

These three studies represent a tiny portion of the scholarship on reproductive technologies, but it is notable that they come to totally opposite conclusions. Differences in methodologies and population samples likewise result in varying outcomes. Many studies follow fairly small samples of (often demographically similar) women and most do not consider age as a confound, despite the fact that many women thicken as they age, suggesting that an overweight cohort may also be older than a "normal" weight cohort (Sneed et al). It is important to note that studies also almost uniformly begin by looking at people who have sought reproductive technologies. Even if the data on these populations were more conclusive, the final analysis would only suggest that fat infertile people may experience different issues than thin infertile people; nonetheless, findings are often extrapolated to assume that fatness *produces* infertility. Furthermore, many studies ignore the possibility that there may be third variables that account for both high weight and infertility. One exception is Howards and Cooney who examine Polycystic Ovarian Syndrome (PCOS), a common cause of infertility in women:

> PCOS is well known to be associated with obesity and with reproductive failure. Without adjusting for PCOS, it is unclear whether the difference in IVF success across BMI strata is due to changes in the proportion of women with PCOS or actually due to BMI. It is possible that the entire observed effect is due to PCOS and not BMI in and of itself. (1604)

In light of this finding, it is not only cruel, then, to ask women to lose weight to begin reproductive treatment, but it also might be impossible for some women when the very hormonal problem that is preventing pregnancy is likewise adding pounds. Yet such women will be refused treatment until they can bring their weight "under control."

Control

It would appear that in the realm of reproduction, as in many other sites of

fat-phobia, weight loss is recommended as a means of keeping an unruly population under control, rather than truly a means to a healthy end. As Deborah McPhail argues regarding weight loss drugs,

> Advertisements for weight loss pharmaceuticals provide a small example of how discourses of emotional obesity were employed in the 1950s and 1960s as a "backlash" against women demanding control over their own bodies and, relatedly, to women entering the public sphere to work for wages. (n.p)

Fat women are denied treatment as a means of controlling fat bodies, yet ironically, people seeking reproductive technologies are affirming the normative role of femininity by attempting to procreate. This is not only the imperative put on female bodies, but especially plump female bodies. Carla Rice, for example, argues that "…women have a higher percentage of body fat than men, because fat is necessary for menstrual and reproductive functioning" (311). Given the biological determinism that has a stranglehold over so much of the performance of femininity, what is the subtext of the move toward denying reproductive options to women of size? The attempt to limit family building to "right" bodies is reminiscent of eugenic discourses that included rapes and forced sterilization. Women with intersecting social locations, particularly poor women, fat women with disabilities or fat women who are racialized may find these discourses eerily familiar. These motifs are not grounded in science or fact, but rather in moral discourses that shift over place and time.

Given the inconsistency of the medical data, it is arguable that the villainizing of fat infertile bodies is guided more by dominant discourses about both fat and motherhood than sound medical logic. The dominant discourse of Western motherhood expects women to be simultaneously nurturing, giving, pliant, self-effacing, and committed to their children above all else (Hays; Douglas and Michaels). "Good" mothers are also energetic so that they can ensure that the many absolute needs of their offspring (and, in many readings, their virile male spouse) are met.[3] By contrast, fat bodies are read as lazy, selfish, dirty and thoughtless (LeBesco). Fat people are "a burden on society," and "sucking our tax dollars." Fat women are either desexualized or, especially in the case of fat black women, are shown as rabidly sexual (Hartley), in either case setting bad examples for their children and neglecting their spouses. If good mothers are Betty Crocker (or, in the modern example, a Mayim Bialik-Angelina Jolie hybrid), then bad mothers are brown, round Kim Kardashian, or Honey Boo-Boo's poor, fat mama, June. The disconnect between an idealized maternity and a demonized fatness is not, unfortunately, limited to artificial reproductive technologies. Fat infertile women who have found themselves halted by the

gatekeepers of ART are increasingly finding themselves cut off from another site of family building: adoption.

Adopting, the Rhetoric

Adoption is an extremely complicated topic and brings up a lot of issues around family composition, normative expectations of parenthood, grief and loss. These issues are compounded in the case of international adoption where ideas around belonging, citizenship, and race may also be present. A full analysis of adoption is obviously beyond the scope of this article. Nonetheless, in considering the ways that families are made, an analysis of the limitations placed on fat people in the realm of adoption is overdue.

The limited scholarship on domestic adoptions and weight discrimination tends only to note that in some U.S. jurisdictions, prospective adoptive parents who are fat are being denied adoptions (Collier; DeVries). The same discourses that guide reproductive technologies (that fat is a choice and that fat is unhealthy) are used in these cases through arguments about "the best interests of the child" (Herndon; Zivkovic). Specifically, fat adoptive parents are viewed as both insufficiently energetic and likelier to die young and, even in cases where children are already placed in foster care in families, adoptions have been denied (Collier; DeVries). Specific recourse to any rhetoric of discrimination is impossible in such cases, both because of the limited protections afforded fat people under law, and because adoption is not seen as an intrinsic right (DeVries).

While discrimination against fat bodies is still largely anecdotal in the context of domestic adoptions, international adoptions from certain jurisdictions, namely Taiwan, South Korea and China, have explicitly banned potential parents above specific BMIs (Collier; DeVries). In the case of China, this ban was part of a broader trend in 2007 toward designating many non-normative people as no longer eligible for adoption. The list includes single parents, those who have divorced more than once, blind or deaf people and gay people, people who have undergone organ transplants and people who are over fifty. Also barred are people who use wheelchairs and anyone who has used an anti-depressant over the last two years. And, finally, people who are obese are no longer permitted to adopt from China (DeVries).

The list of ineligible parents is discriminatory in a wide range of ways. Beyond the obvious implications of this list, however, it is interesting to note which conditions are viewed as linked in the context of a list of identities presented as antithetical to parenting. On the one hand, China, in particular, does not want people who are socially disreputable—people who are single, old, queer, mad, or serial monogamists. On the other hand, China does not

want its children adopted by people who are disabled in any respect, itself a deeply problematic position suggesting that disabled people are unworthy of parenting. Finally, however, China's doors are closed to people who are fat, people who seem to live between these two realms as both morally bankrupt and physically impaired. Noted fat activist and scholar Charlotte Cooper has skillfully drawn out the analogy between fat and disability in her article "Can a Fat Woman Call Herself Disabled?" Significantly, Cooper argues for the application of the social model of disability, which suggests that the impairments are with oppressive and normative societies, rather than different bodies and abilities. This reading can be usefully applied to the study of fat bodies. Cooper's provocative spin is interesting when considering international adoption which may reify many different kinds of normal while helping only particular people build families.

International adoption, however, is not only about building family, but is also about the push and pull of building nation. When the Chinese government allows only certain types of people to adopt, they are making clear their beliefs about the circumstances under which Chinese children should be raised. International adoptees inhabit a "transnational sensibility" that presents a liminal identity (Friedman and Schultermandl). As racialized people adopted into Western societies, and often into white households, they live at the intersections of immigration, racism and cultural understanding. While Chinese adoptees will go on to assume the citizenship of the countries into which they are adopted, the explicit prohibition of particular parents suggests that their government of origin believes they know more about standards of appropriate parenthood than the countries to which children are sent. There is a sense that to do right by these children is to ensure that the value system of their culture of origin is respected regardless of the culture of their upbringing. There is solid evidence to suggest, indeed, that it is imperative that international adoptees become knowledgeable about their cultures of origin. In prohibiting non-normative parents, however, China does not ensure that children who leave China are maintaining their Chinese identity; rather, they merely ensure that these children are not exposed to parenting that is viewed, by some measure, as deficient.

IVF presents an alternative narrative of family building as contributing to nation-building. The UK, U.S. and Canada provide very limited levels of funding to women undergoing IVF through national and private health insurance plans.[4] Daphna Birenbaum-Carmeli finds that in Israel, by contrast, "Publicly-funded IVF is provided practically without limitations, for a wide range of indications, with minimal payment at the point of delivery. Women of all ages, marital status and sexual preference are entitled to treatment, until they have two children from the present relationship" (900).

Far from seeing Israel as a bastian of common-sense among other harsh national policies, Birenbaum-Carmeli documents that the fervent support for IVF is a product of a pronatalist culture intent on nation building through burgeoning population. This pronatalism is born of the specific political circumstances in Israel that allow government to see an increased birth rate as a national imperative. Birnbaum-Carmeli argues that many physical issues affecting women in mid-life are comparatively ignored, suggesting that the focus on fertility has a broader agenda than mere compassion. These examples suggest that an examination of family-building policies, including who is, and who is not, permitted to engage in growing families, has implications in both personal and national realms.

Conclusions

The ways that societies and nations build families has implications for who is viewed as worthy of parenthood. This is especially true for women in an era of increasing child-centredness and discipline of maternity. In light of the evidence that fat women are being held back from motherhood when it is not spontaneously achieved, what changes would need to be made to move toward a more fat-friendly position?

In the medical realm, fat bodies must increasingly be viewed as variations on normal, especially as such bodies become the demographic majority in many Western jurisdictions. For much of history, women's bodies were presented, in many medical contexts, as difficult and deviant since they did not meet the normal (i.e., male) model. Perhaps instead of vilifying fat people, the medical establishment needs instead to learn how to work with a more rotund physique and with a more open mind. To quote Wann, "Weight discrimination will continue to thrive so long as efforts to end it focus on changing people's bodies rather than changing people's minds" (xviii). Such a change might also allow for the pursuing of a causal link for both fat and infertility for some women.

In the words of the Atlantic and Prairie Women's Health Centres of Excellence, "Health care practitioners' experiences of providing maternity care to overweight or obese women remain a subject that requires further research" (Bernier and Hanson 2). The need for further research is especially important given that body shape, weight, and composition vary significantly across ethnicity and race and thus non-normative women may be differentially effected by the desire to limit reproductive options to fat women (Gillett et al.). Likewise, the different ways that reproductive technologies are funded (or not funded) presents different implications for differently classed women. Adoption similarly has implications for race, class, sexuality and ability (among other areas) and these markers need to be intersected with an analysis of fat. A

thorough critical analysis would begin to consider fat bodies as just examples of the many possible ways that bodies may look, and would allow families to emerge in a wider range of shapes and sizes.

Endnotes

[1]Both "overweight" and "obese" are contentious words. Medically, they translate to particular benchmarks on the BMI (Body Mass Index) scale. BMI, however, is a notoriously weak measure of health and of fat distribution or content. Fat activists and scholars have chosen instead to use the word "fat" as both a reclamation and an indication of fat as a floating signifier—fat may be used against many bodies in many different ways but resists strict definition. Likewise, I follow fat scholars such as Rothblum and Solovay and fat activists such as Harding and Kirby in avoiding words such as obese or overweight unless I am writing of the specific medical parameters that are being presented.
[2]While a full analysis of the limitations of correlating fat and ill health is beyond the scope of this article, readers are encouraged to look to Glenn Gaesser's *Big Fat Lies* (2002), Jeffrey Friedman's article "Modern Science versus the Stigma of Obesity," and "Weight Science: Evaluating the Evidence for a Paradigm Shift" by Linda Bacon and Lucy Aphramor.
[3]It is also notable that "good mothers" are overwhelmingly presented as white while "bad mothers" are often shown as racialized.
[4]The specifics vary based on diagnosis, jurisdiction and particular policy, but Ontario, for example, only funds women with blocked fallopian tubes (Birenbaum-Carmeli).

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