“IT MAKE ME FEEL LIKE I’M BENEATH THEM”: EXPERIENCES OF STIGMA AMONG INDIVIDUALS LIVING WITH FOOD INSECURITY

by

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ABSTRACT

RACHEL URI. “It Make Me Feel Like I’m Beneath Them”: Experiences of Stigma Among Individuals Living with Food Insecurity. (Under the direction of DR. VIRGINIA GIL-RIVAS & DR. JENNIFER WEBB)

Food insecurity represents one of the most prevalent and severe problems facing modern United States (U.S.) society, with the proportion of households affected surging to approximately 23% during the COVID-19 pandemic. While several food safety net services exist to reduce food insecurity, previous research suggests that stigma associated with use of these resources may serve as a barrier to utilization, with powerful implications for health. Individuals living with food insecurity report “hidden costs” of using food banks and pantries, including embarrassment, shame, and lowered self-esteem, as well as negative interactions with service providers. This study employed a qualitative approach to investigating how individuals who experience difficulties meeting their food-related needs perceive and manage stigma. Semi-structured phone interviews were conducted with 17 women who use food banks and food pantries in the Charlotte metropolitan area of North Carolina. The interviews were transcribed and analyzed, guided by constructivist grounded theory. Participants described several factors that influenced their perceptions and experiences of poverty-related stigma within food banks and pantries, leading to a variety of reactions and responses to cope with stigma. These narratives were examined using an intrapersonal lens and integrated with prior psychological perspectives on social stigma, while a conceptual model explaining stigma processes was constructed to illustrate findings. Finally, implications, limitations, and future directions of this research are discussed.

Keywords: food insecurity, social stigma, food banks, food pantries, poverty

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CHAPTER 1: INTRODUCTION

Food insecurity currently represents one of the most widespread and severe problems facing modern United States (U.S.) society. In 2019, 10.5% of U.S. households experienced difficulties obtaining food of sufficient quantity and quality, due to a lack of financial and other resources (Coleman-Jensen, Rabbitt, Gregory, & Singh, 2020). However, since the beginning of the COVID-19 pandemic, national prevalence of food insecurity is estimated to have surged up to 23% of households in 2020 (Schanzenbach & Pitts, 2020), necessitating urgent aid and action. Importantly, food insecurity differentially impacts disadvantaged groups in the U.S. which is evident across decades of census research (United States Department of Agriculture, 2018 [USDA]), reflecting social and structural inequalities in access to food.

Most recent national statistics indicate that food insecurity disproportionately influences households earning annual incomes below 185% of the Federal poverty threshold (29.1%), families with children (13.9%), and families headed by a single woman (27.8%) or a single man (15.9%) (Coleman-Jensen et al., 2019). Moreover, food insecurity unduly affects racial/ethnic minorities, with heightened prevalence rates amongst Latino (16.2%) and Black, non-Hispanic (21.2%) households (Coleman-Jensen et al., 2019), as well as sexual/gender minorities, with approximately 27% of LGBTQ+ adults experiencing food insecurity in the last year (Wilson & Conron, 2020). Furthermore, adults living with a disability and/or chronic disease are at higher risk for food insecurity because of restricted options for work and health care-related costs that limit financial resources available to purchase food (Coleman-Jensen & Nord, 2013). Early estimates suggest that these inequities have only intensified during the pandemic (Morales, Morales, & Beltran, 2020; Wolfson & Leung, 2020). Collectively, this evidence indicates that access to and distribution of food is a prevalent and ongoing contributor to health disparities in

the U.S. In a country that sends 30-40% of its food supply ($161 billion worth of food) to landfills (USDA, 2019), food insecurity represents an urgent national problem that has the potential to be addressed through greater attention and action toward improving accessibility, acceptability, and utilization of food resources. Drawing upon extant research, reports, and reviews, this research examines existing conceptualizations of food insecurity in the U.S., situates the problem of food insecurity within the broader context of poverty and needs insecurities, and clarifies the "experience" of food insecurity using the perspectives of people living with it. Taking a qualitative approach to exploring perceptions of stigma among individuals who experience food insecurity and utilize food banks and food pantries, this study seeks to elucidate the ways in which stigma within this specific context may act as a pernicious barrier to health and wellbeing.

Definitions of food insecurity in the U.S.

Examination of current approaches to describing food insecurity indicates that there are several definitions used in research and practice (Barrett, 2010). The USDA primarily defines food insecurity as a lack of "access at all times to enough food for an active and healthy life" (USDA, 2019). Other definitions emphasize components of availability and acceptability, defining food insecurity as "limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways" (Bickel, Nord, Price, Hamilton, & Cook, 2000, p. 6) or "whenever availability of nutritionally adequate and safe foods or the ability to acquire acceptable foods in socially acceptable ways [e.g. without resorting to emergency food supplies, scavenging, stealing, or other coping strategies] is limited or uncertain" (Anderson, 1990, p. 1557S). Thus, common definitions

utilized in the U.S. indicate that food insecurity comprises dimensions of availability, access, use and utilization, as well as stability over time (Ashby, Kleve, McKenchie, & Palermo, 2016). Although prevailing definitions encompass several aspects of food insecurity, these descriptions offer little consideration to the conditions under which food insecurity commonly occurs. Essential to a comprehensive conceptualization of this phenomenon is a greater understanding of its broader social and economic context, and how this context continuously shapes and sustains the experience of food insecurity, inequity, and deprivation.

Food insecurity within the context of poverty.

Holistic understandings of food insecurity necessitate attention to the broader socioeconomic circumstances of poverty. Conventionally, poverty may refer to the inability to access the resources necessary for material wellbeing, such as nutritious food, clean water, and adequate shelter, leading to physical deprivation (Hagenaars & de Vos, 1988). However, poverty may also denote non-material aspects of deprivation and social differentiation, additionally referring to psychological, social, and cultural qualities of impoverishment, including a lack of empowerment and independence, susceptibility to discrimination and inhumane behavior, inability to participate in meaningful cultural and community events and traditions, as well as social marginalization and isolation (World Bank, 2000; Wratten, 1995). Thus, while many previous, economically focused definitions have conflated poverty with income or resource consumption, comprehensive characterizations of poverty are more expansive, encompassing a lack of "physical, human, social, and environmental assets" that confer vulnerability to harm and exploitation (World Bank, 2000), within the background of a "linked ecology of social maladies and broken institutions" (Desmond, 2015, p. 3).

In the U.S., the experience of poverty may include inequities in several multidimensional aspects of essential needs, including safe housing access and affordability, education and

educational attainment, access to healthcare and health insurance, employment and wage, income and benefits, transportation, and internet access, in addition to food security (American Community Survey, 2018; Desmond & Western, 2018). In the 21st century, escalating trends of income inequality and economic stratification in the U.S. maintain and exacerbate such inequities, leading to increasingly severe conditions for those facing persistent challenges to meeting their needs (Guvenen & Kaplan, 2017). Attention to the historical legacy of racism and discrimination in the U.S. is also critical to conceptualizing present-day poverty at both national and community levels. Current racial disparities in the distribution of wealth and economic resources between White and racial minority households, primarily Black and Latino families (Fontenot, Semega, & Kollar, 2018), reflect repercussions of systematic injustice and structural inequity perpetuated throughout the history of the nation (Sullivan, Meschede, Dietrich, & Shapiro, 2015). This context indicates that food insecurity must be considered as just one component situated within a wider, interconnected network of economic and social disparities, informed by historical patterns of inequality and discrimination. Consequently, it is important to keep in mind that the issue of food insecurity extends past a lack of access to nutritious and affordable food; food insecurity also stems from systemic inequalities that impede equitable availability and access to a variety of material, social, and environmental needs. Thus, food insecurity is a problem that involves both individual access to food and structural barriers to entire communities. Considering this complex, multifaceted context, in addition to the issues that food insecurity poses itself, such experiences may have clear implications for health and wellbeing.

Food insecurity and implications for health.

Food insecurity has been linked to many of the principal health problems facing the U.S. population, including cardiovascular disease (Vercammen et al., 2019) and type II diabetes

(Seligman, Bindman, Vittinghoff, Kanaya, & Kushel, 2007; Seligman, Jacobs, Lopez, Tschann, & Fernandez, 2012). This has led to the conceptualization of food insecurity as a leading social determinant of health (Centers for Disease Control, 2019; Marmot & Wilkinson, 2005). Research examining food access and health outcomes has observed a pernicious impact of food insecurity on health regardless of age. For example, food insecure children are more likely to experience birth defects and cognitive problems, adults are at higher risk for developing chronic disease and sleep problems, and older adults experience more limitations in activities of daily living than their food-secure counterparts (Gunderson & Ziliak, 2015). Furthermore, nutritional deficiencies, depression and anxiety, as well as poorer general health have been reported at all stages of development (Gundersen & Ziliak, 2015). Thus, food insecurity represents a persistent barrier to health and wellness for people across the lifespan, as heightened morbidity and mortality are thought to develop as a consequence of living within contexts of material and environmental deprivation, increasing vulnerability and exposure to health risks, limiting access to healthcare services, and advancing experiences of chronic stress and pain (WHO, 2005). Furthermore, the health impact of chronic stress arising from the experience of living in poverty has been well established (Marmot & Brunner, 2005).

The effects of food insecurity on health and wellness may stem from barriers to accessing and purchasing affordable, nutritious foods to sustain healthy living. Many low-income communities live in “food deserts”, where there is a dearth of supermarkets, grocery stores, farmer’s markets, and other healthy food providers (Story, Kaphingst, Robinson-O’Brien, & Glanz, 2007; Rhone, Ver Ploeg, Dicken, Williams, & Breneman, 2017), impacting quality of diet by restricting opportunities to regularly consume essential nutrients and vitamins. For example, research has demonstrated that both perceived and objective distance to supermarkets amongst low-income communities are associated with lower fruit and vegetable intake (Caspi, Kawachi,

Subramanian, Adamkiewicz, & Sorensen, 2012). Moreover, limitations in the variety, quality, and convenience of affordable, nutritious foods may present further challenges to healthy eating behavior and food preparation within a culturally appropriate context (Story et al., 2007). Another barrier to accessing nutritious food is pricing. Elevated costs of high-nutrient and potentially perishable foods, such as fresh produce and other whole foods may lead food purchasers with limited budgets to rely on foods that are lower cost, yet energy dense and poorer in nutritional value, such as refined, prepared, and prepackaged foods (Drewnowski, 2004).

The detrimental impact of food insecurity on health may also relate to the fact that individuals and families living with food insecurity experience persistent or intermittent disturbances in food intake and eating patterns (Nord, Andrews, & Carlson, 2005) as a result of challenges to accessing and utilizing food resources. Studies have documented a "cycle" of food deprivation and overconsumption amongst households who have irregular access to food, with voluntary restriction of food intake when money and food resources are scarce, and overeating occurring when families are able to acquire food (Dinour, Bergen, & Yeh, 2007; Olsen, Bove, & Miller, 2007). In particular, this pattern may occur amongst households who utilize safety net services such as the Supplemental Nutrition Assistance Program (SNAP), as reports indicate that after receiving allotments at the beginning of the month, families have less than 25% of SNAP benefits remaining after just 2 weeks (Castner & Henke, 2011). Such disturbances may confer risk to the development and maintenance of disordered eating behaviors (Bruening, MacLehose, Loth, Story, & Neumark-Sztainer, 2012). Specifically, this research suggests that uncertainty regarding the timing, quality, and acceptability of future meals may lead to patterns of intentional dietary restriction when food resources are scarce (Becker, Middlemass, Gomez, & Martinez-Abrego, 2019; Olson et al., 2007) and overeating and binge eating when food does become available (Rasmusson, Lydecker, Coffino, White, & Grilo, 2018; Stinson et al., 2018).

Such environmental and economic conditions, over time, may confer risk for a variety of health problems. For instance, individuals experiencing food insecurity may be at a heightened risk for nutritional deficiencies and poorer general health, compared to those with consistent access to nutritious food (Stuff et al., 2004). Additionally, disturbances to regular eating patterns may lead to disturbances in metabolism (Parker, Widome, Nettleton, & Pereia, 2010) and diet-related chronic disease (Laraia, 2013), as previously mentioned. Importantly, uncertain access to food and inability to eat consistently intensifies the emotional distress (Heflin & Ziliak, 2008) and depression (Maynard et al., 2018) endured by individuals with limited economic resources who may be trying to balance other competing needs (i.e., housing costs, transportation, healthcare costs). Indeed, the experience of food insecurity appears to be closely linked with persistent stress due to lack of financial and social resources. Individuals living with food insecurity regularly report depression, worry, and anxiety (Maynard et al., 2018; Pryor et al., 2016), as well as poorer health-related quality of life (Sharkey, Johnson, & Dean, 2011). Nevertheless, a comprehensive investigation of what constitutes the "experience" of food insecurity from the perspective of those who struggle with food access and utilization is still lacking from the literature.

While informative, these extant studies investigating the associations between food insecurity, eating behaviors, and health tend to be quantitative in nature. This area of research may be enriched by dedicating increased attention to the lived experiences of individuals who must manage food insecurity and health within the context of poverty in their day-to-day lives. By giving a voice to the people behind these emerging statistics, meaningful and acceptable action plans to improve health and fulfill the needs of food insecure communities may begin to be developed through participatory research. One troubling occurrence related to food insecurity

that has not been reflected using quantitative methods, yet appears frequently among qualitative research emphasizing such narratives, is the experience of poverty-related stigma.

The experience of stigma relating to poverty and food insecurity

Current understandings of social stigma relating to poverty. Stigma refers to the confluence of interrelated components associated with human characteristics, dominant sociocultural beliefs, social status, and power (Link & Phelan, 2001). Stigma originates from the simple tendency to identify, distinguish, and assign social labels to human differences (Goffman, 1963), yet is dependent upon a series of much more complex sociocultural mechanisms that create an imbalance of social, economic, and political power (Link & Phelan, 2001). These processes include the connection of labels with prevailing sociocultural beliefs that convey negative meaning or devaluation within particular contexts (i.e., stereotyping; Crocker, Major, & Steele, 1998), the use of social labels to institute a clear divide between "us" and "them" (Devine, Plant, & Harrison, 1999), loss of social status as well as individual, institutional, and structural discrimination of members of the targeted group resulting in marginalization, exclusion, relative disadvantage, and social inequality (Link & Phelan, 2001; Pincus, 1996). This conceptualization highlights that the phenomenon of stigma rests inherently upon social dynamics of power, suggesting that the experience of being stigmatized may have a multitude of negative downstream consequences impacting the lives of individuals, communities, and society at large (Link & Phelan, 2001). Within the context of poverty specifically, social marginalization as well as inequities in power and privilege are used to restrict access to basic resources that are necessary for security and wellbeing in today's U.S. society (Lott & Bullock, 2007). Furthermore, stigma may be both "enacted" and "felt" (Scambler, 1998); enacted stigma refers to discrimination and acts from others that communicate unacceptability, while felt stigma signifies individuals' internalization of stigmatizing messages and fears related to these experiences. Both

forms of stigma are thought to threaten self-esteem and self-concept, impairing health, wellbeing, and quality of life (Scambler, 1998).

Findings from prior research. Qualitative research examining the ways in which people perceive stigma associated with their socioeconomic position and social identity have demonstrated a wide variety of stigmatizing experiences that individuals living in poverty may face as they attempt to meet and manage their needs, including embarrassment, social exclusion, as well as demeaning social interaction and differential treatment (Allen, Wright, Harding, & Broffman, 2014; Collins, 2005; Martinez-Hume et al., 2016; Nichol, 2018; Reid, 2004; Reutter et al., 2009). It is critical to note that these experiences of stigma are not constrained to the context of food insecurity; stigma relating to economic status may be experienced in a variety of situations, including housing instability and homelessness (Lott & Bullock, 2007; Nichol, 2018; Phelan, Link, Moore, & Stueve, 1997), uncertain access to health insurance or use of public health insurance (Allen et al., 2014; Martinez-Hume et al., 2016), and job insecurity and utilization of welfare services (Lott & Bullock, 2007; Nichol, 2018; Pinker, 2017), and as well as in a range of settings and environments, such as hospitals and other healthcare facilities (Allen et al., 2014; Martinez-Hume et al., 2016), government agencies (Nichol, 2019; Reutter et al., 2009), and schools (Horgan, 2007; Nichol, 2018). Prevailing qualitative data reflect experiences of discrimination due to economic status, or enacted stigma, in addition to feelings of humiliation and shame, as well as expectations of unfair treatment as a result of one's status, or felt stigma (Scambler, 1998). Notably, the majority of this research focuses on the experiences and perceptions of stigma of individuals living with basic needs insecurities, rather than the perceptions and attributions that people hold towards those who are impoverished.

Evidence of enacted stigma from this area of research indicates that participants report individual and structural experiences of stigma within institutional and organizational contexts

implementing safety net programs and enacting poverty reduction policies (Allen et al., 2014; Collins, 2005; Martinez-Hume et al., 2016; Reutter et al., 2009). Many of those who are eligible for safety net programs (such as SNAP, food pantries, soup kitchens, etc.) or may benefit from policies targeting economic need report a variety of negative experiences when attempting to utilize these services. Some participants have reported dissatisfaction with their interactions with service providers and other institutional/agency figures, perceiving interactions as mistrustful, offensive, non-empathetic, and degrading, and experiencing a sense of being watched or monitored (Collins, 2005; Reutter et al., 2019).

Individuals also point out that the way that the services themselves are implemented convey a stigmatizing experience for those who stand to benefit from them. Many individuals seeking assistance from food pantries and food banks perceive "hidden costs" (Purdam, Garrat, & Esmail, 2015, p. 1079) of utilizing such services, including shame and embarrassment relating to the eligibility process (i.e., documentation and determining whether someone is "poor enough" to receive food assistance; Garthwaite, 2016; Papan & Clow, 2015; Purdam et al., 2015), in addition to being required to wait in long lines at inconvenient times to obtain needed food resources (Nichol, 2008) or traveling long distances to access services (Purdam et al., 2015).

Moreover, many people struggling with food insecurity express that the quality and quantity of food that they receive are not sufficient; for example, food bank users indicate that the food they are able to access is "cheap", low in nutritional value, and not of the best quality available (Papan & Clow, 2015; Purdam et al., 2015; Reutter et al., 2009), in addition to the fact the quantity of food provided is inadequate to sustain regular eating throughout the month (Purdam et al., 2015). Furthermore, some individuals have reported situational cues, such as the cold, sterile physical environment of some food banks and food pantries, which leads to feelings

of stigma as well (Garthwaite, 2016). Such experiences convey that people utilizing these services belong to a social group that is "other" from that of more affluent individuals (Lister, 2004), demonstrating that having access to a balanced, nutritious, and consistent diet is "a luxury that's for someone else" (Papan & Clow, 2015), and that they are "undeserving" of something better (Reutter et al., 2009).

Occurrences of felt stigma relating to poverty and socioeconomic status also appear frequently throughout this area of qualitative research. Interviews with both safety net service providers and clients reveal a deep sense of shame and embarrassment associated with utilizing such services (Collins, 2005; Garthwaite, 2016; Nichol, 2018; Papan & Clow, 2015; Purdam et al., 2015; Reutter et al., 2009); lowered self-esteem, humiliation, making the difficult choice to utilize food banks and other safety net services at the expense of one's sense of dignity are commonly reported. In particular, individuals with full- or part-time jobs seeking assistance from food banks and food pantries express frustration around using such services despite being employed, embarrassed that someone they work with may recognize them (Nichol, 2008). Moreover, this literature reveals that people living with economic instability and needs insecurities are acutely aware of the negative meaning associated with the label of "poverty", reporting that others' attributions for poverty converged upon several common themes. The topic of "deservingness" for one's socioeconomic position (i.e., "they think we deserve what we get") appears frequently throughout the poverty stigma research, with tropes of laziness, choosing to "live the easy life", not taking advantage of available opportunities as common attributions for causes of poverty (Reid, 2004; Reutter et al., 2009). Closely related to this experience is the sense that others believe individuals benefiting from safety net services and poverty reduction policies are a "burden on the system" and undeserving of such assistance, viewing them as a

liability to taxpayers, “freeloaders”, irresponsible spenders, and even criminals (Reid, 2004; Reutter et al., 2009).

Experiences of both enacted and felt stigma have powerful implications for the health and wellness of individuals living with food insecurity, contributing to population health disparities (Hatzenbuehler, Phelan, & Link, 2013). Although few quantitative studies have sought to examine the role that poverty and needs-related stigma play in determining overall health, one study reported that 13% of the impact of poverty on allostatic load is due to perceived discrimination (Fuller-Rowell, Evans, & Ong, 2012), echoing the findings of this body of qualitative literature.

Though these existing sociological and ethnographic approaches clearly illustrate the structural and interpersonal contexts in which stigma is perceived, they lack consideration to how people appraise instances of enacted stigma in their environments and manage felt stigma related to these experiences. Additionally, while rich in informative content, existing qualitative research focusing upon poverty-related stigma lacks a clear connection to the experience of food insecurity specifically, in addition to an explicit account of how this type of stigma may contribute to health and wellness within the context of food banks and pantries. Furthermore, many of these qualitative studies have been conducted in other countries, primarily Canada (i.e., Papan & Clow, 2015; Reutter et al., 2009) and the United Kingdom (i.e., Garthwaite, 2016; Purdam et al., 2015), where provision of safety net services to address food insecurity may be different from that in the U.S. In the U.S., the federal government collaborates with food safety net services at the state and local levels to provide assistance to individuals and families facing food insecurity (USDA, 2019). Federal food assistance programs that are unique to the U.S. primarily include SNAP, as well as the Special Supplemental Program for Women, Infants, and Children (WIC), both of which require the completion of complicated paperwork, as well as

fulfillment of strict criteria for economic need, often excluding those who may benefit from such resources but do not meet the benchmarks established by the government. Public and private safety net services at state and local levels, such as food banks or pantries, soup kitchens, and school meals programs, provide assistance through serving eligible individuals within the community; oftentimes, these local agencies have additional requirements for receiving services. Finally, existing research lacks attention to how people perceive and cope with stigma in food safety net contexts. Consequently, health sciences are currently unaware of the extent to which stigma impacts the health and wellbeing of food insecure individuals navigating safety net services in the U.S., necessitating a comprehensive examination of the insights, detailed narratives, and lived experiences of these individuals in order to enrich current understanding of stigma and health, as well as advance progress towards eliminating stigma within these contexts.

Current study.

Elaborating upon the established quantitative relationships between food insecurity and health, this study utilized qualitative methodology to gain a more detailed, nuanced account of this relationship by emphasizing the role of stigma in the lived experiences of individuals who face food insecurity. Specifically, the current research explored the role that poverty-related stigma plays in the lives of individuals who navigate persistent difficulties to accessing and obtaining acceptable, nutritious food, in addition to meeting other basic needs, while attempting to maintain health and wellness. It examined how individuals consider the ways in which the need for food contributes to their mental and physical health, and how the experience of living with food insecurity influences perceptions of identity and self-concept. Additionally, this research evaluated the ways in which the utilization of local food banks and pantries meets and/or does not meet the needs of individuals living with food insecurity by emphasizing the interactions and exchanges that occur within this setting, the acceptability of products and

services offered, and the perceived significance of using this resource. Finally, this study pursued feedback regarding how the experience of utilizing community food banks may be improved, from the perspective of those who use them.

The present study is intended to add to the larger, interdisciplinary study of poverty, social inequality, and health by examining food insecurity at an intrapersonal level, while also seeking to bring issues of economic disparity, wealth, classism, and socioeconomic status to the forefront of psychological research and discourse. Prior qualitative research has examined food insecurity-related stigma from predominantly sociological and ethnographic perspectives. The current study adds to this existing research by integrating psychological understandings of social stigma with these existing perspectives. Additionally, by focusing on how stigma is perceived and how these perceptions influence individuals' views of themselves, food banks and pantries, and the value of utilizing such services, the present study examined how these experiences act as barriers to utilizing safety net services that have the potential to promote health amongst populations facing food insecurity. Moreover, previous research has been conducted with populations in the U.K. and in Canada; the present study explored how perceptions and experiences of stigma in these countries may extend to populations living in the U.S., and how they differ based on the ways in which food banks and food pantries are operated in this country, within the context of a pandemic. Furthermore, this research aimed to generate a participatory discussion regarding poverty stigma within the setting of safety net services, leading to recipient-informed suggestions to improve the quality of services and reduce barriers to utilization, which prior studies have not evaluated. This information contributes both empirically and practically to the knowledge of how stigma associated with food insecurity may influence use of food safety services by seeking feedback from those who experience food insecurity and utilize these resources.

By bringing detailed narrative evidence from the perspective of community members experiencing food insecurity, this study sought to enrich understandings of emerging statistics and provide a foundation to guide future research and action. The current study utilized a grounded theory approach to generate a conceptual model that reflects the intersections between poverty, food insecurity, stigma, and health/disease, intended to inform succeeding quantitative and mixed-method investigations of these topics. Furthermore, the findings of this research have offered specific, concrete recommendations, directly based on the lived experiences of individuals with food insecurity, to organizations in order to improve provider/recipient interactions and quality of service.

Research aims.

The present research had the primary goal of clarifying and enriching known, quantitative disparities in health by giving voice to the experiences, needs, and values of individuals experiencing food insecurity. Primarily, this study aimed to explore the ways in which individuals living with food insecurity interact with food banks/pantries and other available safety net services to meet the needs of themselves and their families, and how these interactions inform self-concept, self-esteem, and other relevant mental and behavioral processes. This research also endeavored to capture the nuances of experiences of poverty stigma as a barrier to health by examining how 1) people living with food insecurity define "food insecurity" and understand how this contributes to mental and physical health, 2) people experience the constraints of food insecurity and how this may intersect with acquiring other basic needs, 3) experiences of food assistance utilization may be improved. Overall, this study intended to better understand the ways in which stigma related to food insecurity is perceived and experienced within community food banks and use this information to inform organizations of the ways in which experiences of stigma may be reduced within the context of food safety net services.

CHAPTER 2: METHODS

Study context.

The current study took place in the metropolitan area of Charlotte, North Carolina located in Mecklenburg County. The state of North Carolina experiences a rate of food insecurity that is higher than the national average (13.1% compared to 11.1% from 2017-2019; USDA, 2020). Moreover, the prevalence of food insecurity in Mecklenburg County exceeds that of the rest of the state, with 14.9% of households experiencing difficulties accessing enough food (Gundersen, Dewey, Kato, Crumbaugh, & Strayer, 2017). Thus, food insecurity represents a widespread, enduring issue currently facing the city of Charlotte and its neighboring areas. To meet the high need of individuals and families facing food insecurity in the community, Charlotte and its surrounding municipalities (Davidson, Huntersville, Concord, etc.) offer several local safety net resources to address food access and utilization. Large-scale, public, non-profit food banks, such as Second Harvest Food Bank of Metrolina, provide the majority of food assistance in Mecklenburg County (Feeding America, 2019). These traditional food banks offer food safety net services to the community by partnering with local agencies (i.e., churches, schools, and community centers) to increase access to food resources throughout the area (Second Harvest, 2019a). Like many other local food banks across the U.S., most food banks and pantries operating in the Charlotte require potential recipients to meet eligibility criteria to establish need for services, such as evidence of monthly income or a referral from a local human service agency (Loaves and Fishes, 2019; Second Harvest, 2019b). Since the outset of the coronavirus pandemic, community food banks and pantries have been overwhelmed with the rising level of need, attempting to expand services in some ways (i.e., through delivery services) but limiting services in others (i.e., reduced quantity of food provided; Leonhardt, 2020).

Participants in the present study were recruited from the Hearts and Hands Food Pantry located in Huntersville, North Carolina. The Hearts and Hands Food Pantry is a privately owned and operated 501(c)(3) organization that serves individuals and families living in Huntersville and the greater Charlotte metropolitan area. Relying on donations and food rescue, the Hearts and Hands Food Pantry independently provides the community with emergency and temporary food assistance. The pantry operates on Tuesdays and Thursdays from 3:00-6:00 pm, year-round. Prior to the pandemic, the pantry served 100-150 people per month, and saw increases in utilization up to 300 people during the holiday months. However, during the COVID-19 pandemic, the pantry has seen a 650% increase in clients (Hearts and Hands Food Pantry, personal communication, March 22, 2021). Since the beginning of the pandemic, Hearts and Hands have responded quickly and intentionally to meet the growing needs of the community. Specifically, the pantry now offers curbside pickup services and delivery for individuals with disabilities and older adults. Moreover, the pantry has updated their website to allow clients to view and select available items and customize their orders to best meet their specific needs. The pantry has also become a member of NCCARE360, a statewide network that connects healthcare and community providers, to increase access to individuals in need.

There are several aspects of the Hearts and Hands Food Pantry that differ from traditional, larger-scale food banks and food pantries mentioned previously that exist in the Charlotte community. Primarily, the Hearts and Hands Food Pantry does not require proof of eligibility to access food and other supplies, serving anyone who seeks assistance. Although this limits the frequency of Hearts and Hands' ability to offer aid (individuals may visit once every 2 weeks), this policy eliminates a potential structural barrier for individuals who may be employed or who lack official identification documents (such as a social security number). Moreover, Hearts and Hands offers a variety of other basic material needs such as clothing, baby supplies,

and hygiene products that may be useful to those who utilize the pantry. Finally, individuals and families who visit the Hearts and Hands Food Pantry interact with and receive assistance from a small group of staff members who are not only personally invested in the food pantry, but also maintain ongoing relationships with those who regularly utilize its services.

Hearts and Hands Food Pantry was chosen as the partner organization for the present study because of its ongoing commitment to serving the community, long-standing rapport with individuals and families living in Mecklenburg County, and mission to reduce barriers to food access. Moreover, their willingness to collaborate in this participatory research endeavor signifies their dedication to improving the experience of those who utilize food safety net services. Although Hearts and Hands may exemplify the ways in which food pantries better meet the needs of those facing food insecurity by reducing perceptions of structural- and individual-level poverty-related stigma, the resources and services provided are limited, which may lead individuals and families to seek out safety net service elsewhere in the community. Drawing upon the close relationships Hearts and Hands Food Pantry maintains with community members, the current research explored food pantry utilizer's perceptions and experiences with poverty-related stigma in their encounters with these other safety net services in the greater Charlotte area.

Study design and participants.

The present study used constructivist grounded theory perspective (Charmaz, 2006). Grounded theory provided a basis for strategically exploring stigma processes within the context of food insecurity and setting of food pantries, with the intention of generating explanatory theory that may clarify participants' perceptions and shape future research inquiries (Glaser & Strauss, 1967; Marshall & Rossman, 2016). Furthermore, in this constructivist approach,

participants were considered partners in co-creating knowledge pertaining to food insecurity, hunger, stigma, and health (Charmaz, 2000; Charmaz, 2006; Mills, Bonner, & Francis, 2006). Additionally, the researcher's dynamic role in shaping the collection and interpretation of data was considered through continual reflexivity throughout the progression of the study (Finlay, 2002).

To gain detailed insight into the perspectives of community participants, data were collected through semi-structured interviews. This approach intended to allow participants relative autonomy in directing the structure and course of the interview and flexibility in capturing nuances of participants' responses, while also ensuring that the information shared by participants is pertinent to the topic of stigma relating to food insecurity and the food bank environment. Due to the COVID-19 pandemic, all interviews were conducted via phone in compliance with social distancing guidelines. All study materials and procedures were approved by the University of North Carolina at Charlotte's Institutional Review Board.

Participants were recruited using a theory-based purposive sampling strategy to identify individuals who perceive stigma in relation to food insecurity and utilize food banks and food pantries. Recruitment flyers were placed in client food parcels assembled by the Hearts and Hands Food Pantry in order to reach current clients of the food pantry. Flyers generally detailed the research being undertaken and contained a QR code and a link to a Qualtrics survey to establish study eligibility. To be eligible to participate in the current study, individuals had to meet the following inclusion criteria: 1) report the perception of stigma in relation to food insecurity and/or utilizing food banks and pantries, 2) have had at least one experience of visiting a public food bank or food pantry that requires some evidence of economic need, and 3) be at least 18 years of age. Accordingly, the study sought to obtain a sample of individuals who have perceived some degree of stigma in relation to their experience with food insecurity and food

bank utilization at traditional (and possibly non-traditional) safety net service sites. Consistent with the grounded theory approach, sampling took place throughout the data collection processes, in conjunction with interviewing and analysis processes (Glaser & Strauss, 1967).

Procedure.

Semi-structured interviews were conducted via phone at a time agreed upon by both the participant and the researcher. Each interview was recorded using two digital voice recorders. During interviews, the researcher took note of any relevant observations, questions, concerns, or events (including reflexive information) on a pad of paper. Interviews lasted from 30 minutes to 1 hour. Prior to taking part in semi-structured interviews, all participants were asked to read and electronically sign an online consent form and were encouraged to reach out to the lead researcher with any questions or concerns. At the outset of interviews, the researcher and participant also engaged in a discussion regarding general information about the focus and aims of the study, the nature and process of the interview process, willingness to be recorded, and steps that are taken to ensure privacy and confidentiality. The researcher also reminded individuals of their rights as participants (not obligated to answer any questions and are permitted to refuse to answer any question, may take a break from the interview if needed, and may stop the interview and withdraw from the study at any time). Participants were given an opportunity to ask any questions or voice any concerns prior to providing verbal informed consent and commencing the interview.

To direct semi-structured interviews, an interview guide (Appendix A) consisting of questions and corresponding prompts was developed consistent with theoretical conceptualizations of stigma in order to capture stigma-related experiences within the context of poverty, food insecurity, and utilization of safety net services. Questions explored participants' own experience of food insecurity and awareness of how it may be related to health and other

needs insecurities, their perceptions of stigma related to food insecurity and how these perceptions influence their self-esteem and self-concept, experiences of stigma when using food banks and food pantries in the community, and the ways in which operations and services of these safety net services might be modified to reduce stigma. A question about how the COVID-19 pandemic has affected participants was also included to assess how the pandemic has influenced food bank and food pantry utilization. At the end of the interview, participants were debriefed regarding the specific purpose and goal of the current study. All participants were also mailed a $25 gift card to a nearby grocery store, as compensation for the time they dedicated to taking part in this research. After interviews were transcribed and coded, participants were asked to engage in "member checks" (Krefting, 1991) to ensure that the researcher gleaned an accurate understanding of their words. Participants were asked for their consent to contact them (via their cell phone or email address) at the end of the interview, were provided with a summary of interpretation, and engaged in a brief phone meeting in which the theoretical content and meaning of their interviews were discussed and verified with the lead researcher. Member checks were completed for 13 (76%) participants; no revisions were made based on member checks.

Privacy and confidentiality were safeguarded in several ways throughout the study. First, participants were asked to choose a pseudonym to use throughout the interview and in data analyses to protect their identities. All written notes and other paper study materials were stored in a locked filing cabinet in a locked lab space. After interviews, all audio recordings of interviews were uploaded to a secure server no less than two hours after the interview concluded. Finally, audio recordings and their transcriptions were stored on a password-protected Google Drive folder.

Training and responsibilities of the research team.

The research team was directed by the lead researcher, R.U., a third-year graduate student in clinical health psychology. Prior to the present study, R.U. has assisted with qualitative and mixed methods research and completed two semesters of rigorous coursework focused on qualitative theory, methods, and analysis. R.U. managed recruitment and participant communications, conducted the interviews, and served as the primary coder during qualitative analyses in the present study. R.U. also led all training and meetings throughout the study. Audio recordings of interviews were transcribed by L.B., a post-baccalaureate psychology student. L.B. participated in two trainings in order to learn how to transcribe, establish transcription style (i.e., verbatim transcription), and address any questions or concerns prior to transcribing interviews. A.T., an incoming graduate student in clinical health psychology served as the second coder during qualitative analyses. A.T. participated in several trainings prior to and throughout the course of data collection and analysis. Principally, the purpose of these trainings was to facilitate A.T.'s understanding of the grounded theory approach, use of NVivo, application of the codebook and the coding processes utilized in the present research (i.e., in vivo coding). R.U.'s academic advisors, J.W. and V.G.R., supervised the current research, guiding the development of research and interpretation of data. J.W. and V.G.R. are both Ph.D. psychologists with previous experience conducting and supervising qualitative research.

Plan of analysis.

Interview audio recordings were verbatim-transcribed into typed document files by L.B. Fidelity checks to each interview audio-recording was performed to ensure accuracy of transcriptions. Transcriptions were then transferred to QSR International's NVivo software for coding and data analysis. To enhance interpretation of codes by the lead researcher, an impartial second coder (A.T.) was trained and consulted by the lead researcher throughout the coding and analysis process. This second coder was involved in ongoing coding throughout data collection,

generation of the codebook, as well as additions and revisions to the codebook. Two training sessions were directed to ensure the proficiency of the second coder; the first session focused on learning about the initial coding approach and construction of the codebook, while the second session emphasized comparative coding and adherence to the codebook between sessions. Throughout the coding process, coders also took part in regular peer debriefing meetings (Lincoln & Guba, 1985), in which the coding, interpretation, and concepts derived by the lead researcher were discussed and scrutinized by the second coder. Reliability of coding was analyzed using Cohen's kappa coefficient, reflecting inter-rater consensus (Cohen, 1960; McHugh, 2012). Cohen's kappa values for codes ranged from .67-.93 (Table 1; *M*=.76; *SD*=.09), indicating adequate to substantial agreement (McHugh, 2012).

Table 1. Inter-rater reliability of codes.

Variable	Reliability (Kappa)
Barriers to Food Bank/Pantry Use	.91
Definitions of Food Insecurity	.67
Discrimination or Judgement	.72
Health Consequences of Food Insecurity	.93
Suggested Improvements	.80
Strategies for Managing Food Insecurity	.83
Stigma Beliefs	.71
Behaviors in Response to Stigma	.70
Cognitions in Response to Stigma	.67
Emotions in Response to Stigma	.75
Internalization of Stigma	.69

In the initial phases of the coding process, coding took an open, in vivo approach, in which the participants' exact words and phrases spoken within interviews were utilized to produce a preliminary codebook (Charmaz, 2008). In vivo codes that arose within and between the first and second interviews conducted were then categorized and consolidated to reflect similar concepts and themes, providing a germinal guide by which codes were then classified. Coding then took an axial coding approach consistent with the constant comparative method, an iterative process of contrasting emerging concepts with previously identified key themes and subthemes from earlier transcripts between each interview (Glaser & Strauss, 1967; Strauss & Corbin, 1990). Throughout this secondary coding process, the codebook was amended to reflect new codes, editing of extant codes, changes to the organization of codes, and omission of codes that are no longer relevant (Charmaz, 2008), with previous versions of the codebook preserved. Interviews were conducted until saturation was reached (Charmaz, 2006; Glaser, 2001), which is thought to be achieved when novel theoretical concepts no longer emerge from the constant comparison of data. The iterative data collection and analytic process took place over a span of 5 months, from October 2020 to February 2021. During this time, the interview guide was revised once to include a question specifically asking about sharing food with others (see Appendix A), to further explore the process of sharing, bartering, and trading to meet food needs. The codebook was revised on one occasion, in which some codes were consolidated to reflect broader themes across interviews. The final version of the codebook included eleven broad codes: participants' definitions of food insecurity, participants' strategies for managing food insecurity, the health consequences of food insecurity, barriers to food bank/pantry use, instances of discrimination or judgement at the food bank/pantry, stigma beliefs about people who use food banks/pantries, stigma internalization, participants' emotions , cognitions, and behaviors in response to stigma, and participants' suggested improvements to better food bank/pantry

services. In adherence to the grounded theory approach (Glaser & Strass, 1967), themes from interviews were used to create a conceptual model reflecting the intersections between poverty, food insecurity, and stigma.

Methodological and interpretive rigor.

The present study intended to promote authenticity by utilizing a constructivist grounded theory approach, engaging both the researcher and participants in the co-creation of knowledge and meaning (Charmaz, 2000; Charmaz 2006). Consistent with a constructivist perspective, participants were regarded as experts of their own experiences and perceptions, contributing significantly to the research process and outcomes. To help equalize the power differential between the researcher and participants, participants chose their own aliases and selected the time and date of interviews. As a result of their involvement, participants were asked to provide feedback regarding the ways in which they believe their experiences as individuals facing food insecurity could be improved (with respect to operations of the food bank as well as the community environment and culture more broadly); these recommendations were then consolidated into a research report that will be disseminated to food bank organizers/staff in order to inform operations and improve services.

Several steps were also taken to support the credibility of this research. Credibility of interpretation was promoted through verbatim transcription of semi-structured interviews in addition to in vivo coding. To encourage referential adequacy (Lincoln & Guba, 1985) multiple coders were consulted to interpret interview data, as well as analyze codebooks and interview materials, reviewing for consistency with the grounded theory that the primary researcher has developed. Furthermore, member checks with participants were conducted in order to ensure the accuracy of the initial concepts that emerge from the interview data.

The primary researcher also engaged in a continual process of reflexivity (Finlay, 2002), to promote the trustworthiness and transparency of the current research. Specifically, she focused on her own role in the research process while reflecting on how her experiences may have shaped the ways in which she approached the topic of food insecurity and interpreted interview data. To accomplish this, she kept a detailed reflexive journal throughout the course of the study, documenting her personal responses to the research process and disclosing any potential biases or areas of reactivity. Moreover, the researcher considered her own economic privilege in having not ever personally faced the experience of food insecurity, and how this influences the way she conceptualizes and perceives this phenomenon. Dependability of the study was promoted by keeping an organized archive of raw data, analysis products, data reconstruction and synthesis products, process notes and reflexive journaling, as well as materials and products that were related to the research process. Finally, the current research aimed to enhance transferability by providing a rich description of the context of food insecurity in Mecklenburg County during the COVID-19 pandemic, the setting of the food bank, and the characteristics of participants who were interviewed.

CHAPTER 3: RESULTS

Participants and sample characteristics.

The sample consisted of 17 participants. The sample size was considered satisfactory as theoretical saturation was reached, with no new themes or concepts emerging from the data (Charmaz, 2006). Table 2 provides details on each participant interviewed.

All participants in the present study identified as cisgender women. The mean age of participants was 46 years old (M=46.35; SD=11.52), with ages ranging from 25-67 years old. Over half the sample (eleven participants) identified as Black/African American; additionally, four participants identified as White, one participant identified as Latina, and one participant identified as biracial (Black/African American and White). Participants described a variety of employment statuses, housing situations, and family structures. The majority of participants (eight) were currently unemployed, while three were laid off or furloughed due to COVID-19. Six women were currently employed. Two participants indicated that they were currently homeless or experiencing housing insecurity, and one woman was currently living in a substance use recovery house; all other women had stable housing. Four women lived alone, four women headed single-parent households, and eight women lived with their partners, children, and/or additional family members. Eleven participants discussed living with several health conditions, concerns, and/or disabilities, including four participants with type 2 diabetes and two participants with hypertension. Three participants received monthly disability payments.

Table 2. Participant characteristics.

Pseudonym	Age	Race/Ethnicity	Employment Status	Housing/Family Situation	Chronic Health Condition/Disability?
Tess	38	White	Currently unemployed	Stable housing; lives with partner and baby	Yes (unspecified)
Nicole	25	Latina	Currently unemployed	Stable housing; lives with partner and baby	None mentioned
Jamie	49	Black/African American	Currently unemployed	Stable housing; lives alone	Yes (hypertension, others unspecified); receives disability
Lisa	49	Black/African American	Currently employed (working remotely)	Stable housing; lives with partner and 2 teenage children	Yes (hypertension, physical disability)
Jane	51	Biracial (White, Black/African American)	Laid off due to COVID	Stable housing; lives with 2 children	None mentioned
Mary	50	Black/African American	Recently re-employed after being laid off due to COVID	Stable housing; lives with partner and 2 teenage children, brother	None mentioned
Genie	48	Black/African American	Currently employed (working remotely)	Stable housing; lives with 2 teenage children	Yes (type 2 diabetes)
Tess 2	50	Black/African American	Currently employed	Currently homeless	Yes (unspecified disability and health conditions)
Jane 2	51	Black/African American	Currently employed	Stable housing; lives with partner and 2 adult children	Yes (type 2 diabetes)
Amy	38	White	Laid off due to COVID	Stable housing; lives with partner, parent, and children	Yes (unspecified)
Lee	29	White	Currently unemployed	History of homelessness; lives in hotel with partner and 3 children	None mentioned
Debo	55	Black/African American	Currently unemployed	Stable housing; lives alone	Yes (epilepsy, others unspecified); receives disability
Brittney	27	Black/African American	Laid off due to COVID	Stable housing; lives with family and children	
Mickey Mouse	62	Black/African American	Currently employed (working remotely)	Currently living in substance abuse recovery house with other women	Yes (type 2 diabetes)
Laura	50	White	Currently unemployed	Stable housing; lives with 2 children	Yes (unspecified); receives disability
Latasha	67	Black/African American	Currently unemployed	Stable housing; lives with sister and 5+ children	None mentioned
Sasha	49	Black/African American	Currently unemployed	Stable housing; lives with 2 children	None mentioned

Definitions of food insecurity: Inadequacy, inability, & instability.

Participant's own definitions of food insecurity were characterized by an *inadequacy* of food resources (twelve participants) and an *inability* to meet food needs (seven participants). Women often used the terms "not enough" to describe this experience:

Jane 2: "O *clears throat* not having enough of um food for your needs"

Lee: "We don't always have the ends to make do…we just don't never have enough for everybody"

Laura: "Food insecurity means the inability to have enough food to last for a period of time, um you know within a budget"

Genie: "When the fridge get low"

Some participants responded with their understanding of food *security*:

Amy: "Have-having enough to last at least a whole week. I just like to have enough for everybody to get full, not so much to eat but be able to get full"

Tess: "Oh to make sure I have plenty of food, oh to make sure I have food for my family"

Seven participants characterized the experience food insecurity in terms of its *instability*, describing the periodicity of not being able to meet food needs:

Lisa: "I've been in sales for twenty three years…I've been doing it for twenty plus years, but you find that you get in these ruts, you know, um where-and it comes down to food"

Jamie: "So like some months I don't have the adequate amount of food and have to go to a food bank to um get supply others' needs of food"

Sasha: "I've been on this side and I've been on the other side. I've been there where I was able to provide, I've been where I've-where I've needed to get food"

Two participants detailed how food insecurity is an aspect of a larger network of competing needs insecurities, often describing their ability to obtain food as dependent upon

their ability to meet other needs, such as housing, utilities, and healthcare costs. Participants also noted how financial resources for food tend to be scant when other needs take precedence:

Lisa: "You don't, they don't have enough and people-pe-people are still hungry because there is not enough income to suffice the groceries that's at the bottom of the bill list, groceries go at the bottom of the bill list"

Nicole: "Well it means we really have to um take a look at everything we're spending and how much we're spending…what's going to go for uh for utilities, and what's going to go for food, and what's going to go for this bill and that bill"

"Managing" food insecurity: Navigating the landscape of food resources

In addition to utilizing food banks and food pantries, participants used several different resources for and methods of obtaining food and/or financial resources to meet their food needs. Overall, participants acknowledged that utilizing food banks and food pantries alone was insufficient to meet their food needs:

Latasha: "People at the food banks, they only can do what they can do, they can't help what they have you know…they got to give what they got…they can't just help you on everything"

To secure food needed to feed themselves and their families, six participants shopped at grocery stores, some using strategies to get the most value out of their money available for food:

Mickey Mouse: "I used to go grocery shopping sometimes but the prices are so expensive sometimes you known I can only get some items and then I have to use the food bank to supplement"

Lisa: "So going to the grocery store, you find that you are trying to find items on sale all the time… you kinda just shop according to what's in your pocket and not by what's a healthier source of food for you or you get mark down items that are about to expire basically"

Other ways that participants met their food needs included applying for and utilizing "food stamps" (SNAP or WIC; six participants) and visiting churches and ministries in the area that offer relief resources (seven participants). Participants also mentioned panhandling (Tess)

and rationing (Mary) in order to meet their food needs or make food last. One participant noted how certain resources became inaccessible as soon as she was able to gain marginal security in her life:

Laura: "I was given food stamps, in December, because-but because I moved to [location] and my rent's 40 dollars cheaper, now I don't get food stamps, so I only had food stamps for one month…I just got cut off."

Six participants described the experience of "going without" or simply not eating when food was not available:

Jane 2: "Um I just typically go without…and um if I don't have it, I don't have it"

Latasha: "You just have to make it though, and make out what you got, you ain't got enough, you wait til tomorrow and try it again"

Three women described how they always ensure that their children and other family members have enough food before feeding themselves, which sometimes leads to eating very little or not at all:

Lee: "Because I have kids, so that's-they're my main priority like I-they'll eat before- I mean they'll eat before we [Lee and her partner] do"

Amy: "We'll go without or limit ourselves to like one-like *pause* one meal a day, just to make sure they have what they need…we'll do without to make sure they have"

Five participants talked about sharing, bartering, or trading with other individuals in order to access and obtain food that met their specific needs. This allowed women to obtain specific items they might need, while preventing them from wasting unwanted items received from the food pantry:

Sasha: "Whatever I get that I can't need that I can share with someone else, I definitely do, like if they give me extra you know, I'll share it with my neighbor and with him and he says 'you always bring me good stuff' and sometimes somebody else will also bring me good stuff…so you know that makes me feel good so even though I go, I still get to share with somebody else"

Tess 2: "Yes, and the thing is *pause* you barter. *laugh* Both of us go to the food pantry but I may not eat something you don't eat, so let's trade from these boxes so that we have a win-win situation"

Influence of food insecurity on health and wellbeing.

Participants spoke of the detrimental effect of food insecurity on their overall health. While four participants mentioned experiencing physical symptoms as a result of food insecurity (hunger sensations, headaches, fatigue), twelve participants described how their mental wellbeing as suffered as a result of food insecurity:

Tess: "Not having enough food makes me depressed. It makes me worry. Like I will start panicking…If I'm really low on food an' don't have no money or food stamps or anything, and nobody's answering my phone call or textings, I start panicking"

Mary: "it's just a mental-mental strain to just not know, you know, um where food is coming from…it's all very, very scary"

Laura: "Um I would-I would review my-my budget over and over again because I'm thinking 'What else can I do? What else can I do?'...like you know you can't do it all on disability-on one disability check…I was ashamed, emotional, it-it makes you feel alone."

Six participants also discussed the ways in which food insecurity, specifically the inability to access healthful and nutritious food, makes it difficult for them to maintain their current health, with one participant acknowledging that there may be long-term consequences to this lack access to quality food:

Nicole: "We really just um look at like my like husband's paycheck and then look at how much we have to spend for each thing…ah obviously nothing fancy, just simple stuff…um, which usually doesn't cost as much but then again it's sometimes it's not the healthy stuff. Again, which maybe leads to health issues later on"

Ten participants described how food insecurity impacted their management of existing chronic health conditions and concerns, often acknowledging the health-related consequences of

their situation. Participants noted how this was associated with the inability to access the amount and/or types of food they needed to live healthily:

Brittney: "I definitely feel like if I don't have enough, then my health is impacted especially um because I have health issues…so um for instance if my sugar is really low, um, I have to eat something to try to get, you know, my sugar back up. Um, so if I don't have the food then I'm not able to do that um and doing that it makes me feel sick inside"

Tess 2: "um I need things that are a little more fresher for my health um I need more than just ah just cheese and bread and eggs, you know…you end up getting what you get from the food bank and you make it work and you deal with the health issues later"

Two participants also talked about how food insecurity influenced their ability to adhere to their prescription medications:

Mickey Mouse: "I'm a diabetic and so um I take insulin, so I have to eat enough to sustain the insulin"

Jamie: "if I don't have enough food then I can take my medicine at the accurate, at the appropriate time…um you end up being sick from taking the medicine on an empty stomach or with not enough food"

One participant highlighted the potentially dire health consequences of food insecurity, describing not having enough food to manage her diabetes:

Genie: "On several occasions, you know, where I had to be admitted into the hospital because of the diabetes…it was kind of hard because you know you don't have the money to get the food and everything"

Perceptions of Poverty-Related Stigma in the Food Bank/Pantry Context

Overall, women's rich accounts of their observations and experiences within the food bank/pantry context revealed the intrapersonal processes by which poverty-related stigma is conveyed within this specific environment, in addition to responses and reactions to being stigmatized in this way.

Structural and institutional context of food banks and food pantries. Participants spoke of encountering numerous barriers in their attempts to access and use local food banks and food pantries. As required by study eligibility criteria, all participants were currently or had previously utilized a food bank or pantry in the Charlotte area requiring a referral process to receive services. Fifteen participants overwhelmingly agreed that this referral process served as a significant barrier to food bank access, for a variety of reasons. Predominantly, women talked about how the referral process was time-consuming and required them to divulge a great deal of personal, and often sensitive, information:

Debo: "They ask too much. They want to know how many people in your house, how many-and want everybody's social security number, wanta know if everybody working, wanta know and that's too much for some secondhand food…what's that got to do with eatin'?"

Jane 2: "They don't need to know a whole bunch of information about me, especially my driver's license, they don't need that. I mean, I don't know if people are going to use that for identity thief or what have you, I don't know"

One participant experiencing housing insecurity discussed how the referral process may be particularly tasking for people living with housing difficulties as they may not have the necessary documents on hand:

Lee: "Some places want proof of residency and ID and social security card, some places even want birth certificate also and in some situations we're considered homeless so it's harder to get them to understand that, with some places, not all places, so sometimes you don't get the stuff you need because of the situation you're in…I don't always have everything that you need because we have to move a lot, so, it's-it's-it's 'cause I don't keep everything with me because-because that's stuff that I don't want to lose"

Five participants also discussed how limitations placed on the number of times one could visit the food bank or pantry prevented them from accessing food resources when they were in need, with one participant explaining how some food pantries were strict about following up with referrals:

Mary: "And then they put a limit on it. You can only go once every two weeks or, yeah you can't go every week, so you gotta kinda watch how you, you know, how you use the food"

Tess: "You get up to twelve referrals a year *pause* so, you can only go to the food pantry twelve times in a year now. So if you didn't, if you made an appointment and you didn't get to go. Sometimes they still count as you just even though if you didn't show up they count it as one of your twelve"

The logistics of getting to and from the food pantry emerged as a significant barrier, with eight participants mentioning transportation as a persistent and widespread issue associated with utilizing food banks and food pantries in Charlotte. Five participants also acknowledged the physical burden of carrying the food they receive from the food bank/pantry back to where they were living, which further limited transportation options:

Lee: "Really my biggest thing is transportation to be able to go get it, um, because I don't always have the money to get on the bus to try to go get food"

Jamie: "And then you have to find a way to get there, and get the food back. And me, myself, most of the time I have to be on the bus and it's a lot, a lot of headache to try and carry all that stuff on the bus"

Laura: "The stuff is really heavy *pause* and I have physical disabilities…there's sometimes grocery carts, sometimes there wouldn't be and um if you share a box with somebody else you get told 'no you can't do that' or you don't get the same amount as two people not sharing…getting-getting food's a hard thing but um *pause* you know, you-you can only carry so much on a bus"

Once overcoming barriers associated with accessibility, many women also described how the food received from the food bank/pantry itself sometimes served as a barrier to meeting their food needs, for several reasons. First, the amount or quantity of food received was seen by fourteen participants as insufficient:

Debo: "For that little bit of food that don't last for probably about a week. *cough* They seem to think that's a month's worth but it's not a week's worth"

Amy: "I have, like I said, the last one it didn't seem like it's enough but like I said I'm very grateful *soft laugh* but for a family *pause* I would have thought, you know, they would have at least gave me more"

Mary: "It was not enough to last"

Mickey Mouse: "Um when I guess, like I said they give you what they have so…um *pause* they give you some. It's not enough to take you through the month"

Additionally, the quality and safety of some of the food provided by food banks and food pantries was judged as inadequate by thirteen participants:

Nicole: "But still because some of the things are donated and um they're not always, um, like um the date a lot of the time they are expired. So it's expired things that can perhaps upset your stomach"

Sasha: "Um I mean sometimes you can get stuff that's outdated and that's ah not a good thing"

Debo: "It wasn't really meats and stuff, they give you these little logs of meat it was like brick hard, it was like solidly frozen, probably was about old. Like I said it wasn't fresh, nothing was fresh. Nothing was near fresh, it was all old stuff that was already gettin' rid of"

Laura: "Well generally, some of the food is bad so you have to throw some of it away. You can tell that there's-that mold on it or-or occasionally a bug"

Finally, thirteen women discussed how there was often little variety or relevance in the types of food offered by food banks and food pantries. This particularly pertained to produce and proteins:

Tess: "Like they hardly had any selections or different stuff…I told them you know what I just told them I'll just wait till tomorrow when y'all are stocked and y'all got different options because the stuff that they had, I don't even eat"

Brittney: Um do I feel like they could give more like meat? Um I would definitely at least say that…I definitely think they could give meat"

Jane 2: "Like if I don't get enough meat, and I don't get enough protein in the form of meat or um vegetables…sometimes it's a hit or miss. Um you know one time I got some fresh collard

greens and things like that um but for the most part I don't get any vegetables *cough* and I don't get any meat and that's what I really need"

Women also noted that some of the food received was not personally or culturally relevant to them or their families, which prevented participants and their families from using some of the food items given:

Latasha: "Sometimes the meat that they give…the pack of meat…it's like some kind of meat that's in the bag that's cut up and then when you open it and try to cook it, oh that don't even come that way, it don't even look-it don't even taste right. I don't know what kind of meat that is"

Mickey Mouse: "Um some of the stuff they gave me, I had no idea what it was um because ah, you know, stuff that um may be the Latino community uses more or like different types of beans and stuff they cook, I-I wasn't familiar with it. But some stuff, I've got it but I don't know what to do with it"

Dissatisfaction with the variety and personal relevance of food received from food banks and food pantries was closely tied to the way that many of these organizations operate; specifically, eight women described how at most banks/pantries there is little "picking and choosing" involved when receiving food resources, limiting clients' autonomy and the usefulness of what was provided:

Jane: I don't like the fact that they get to pick, I know it's not a grocery store but they pick out what they think your family eats. You don't know us…for you to just give me a box of stuff that I can't even use, that's-that just defeats the purpose of a food bank"

Tess 2: "You don't get to shop for it, you just get to hope that there's something in there that you can eat…you just get a box, you're not able to shop"

Mickey Mouse: "You're sitting there waiting for someone else to do something for you taking (?), picking your groceries for you…it's just, you-you're just in other words you're feeling like you're just receiving whatever someone wants to give you…you don't have a choice in what you get, you just have to receive whatever it is that they give you"

One barrier that seemed to overlap with and transcend all others was that of time. Twelve participants described how time influences and intersected with other obstacles they encountered when utilizing food banks and food pantries. Moreover, women contrasted the lack of time to get to the food bank/pantry, waiting for food, or not making it to the food bank/pantry in time with the urgency of the need for food. Completion of the referral process to visit food banks and pantries was deemed as a significant time-related obstacle:

Lisa: "I mean, just the referral could delay two or three days of somebody being hungry"

Jamie: "Okay first you have to find um ah someone that can *pause* do a voucher for you. Which is aggravating in itself because *pause* sometimes you don't have like you can't get in touch with a worker or something like it might take a day or two to get in touch with them. And during that time you still be out of food"

Women also discussed how the time it took to find, wait for, and utilize transportation to get to and from food banks and pantries often impeded their ability to receive services, as they could not be physically present to pick up their food at the time of their appointment:

Jane: "You gotta be there at a certain time um and you don't always have a car to get you there you know, then you can miss out"

Tess 2: "I may not have a way to the food pantry. That's one of the things that um it's not a secure thing for me. So I have to either wait until I can get a ride, cause you just can't bring all the food on the bus"

One participant explained how she often worries about being able to make it to a food pantry even before they close, as she learned that the quantity of food resources provided decreased as time passed:

Sasha: "Are you going to be able to go to a food pantry? Are you going to be able to make it in time for the food pantry? Are you going to be able to get enough, be there in time enough when they still have enough food and you be able to get you know a box or whatever 'cause sometimes they do run out"

The time spent waiting at the food bank or food pantry to receive services was also viewed by participants as arduous, whether women were waiting in line or in their cars:

Tess: "It's just the people waiting around to get the food is the problem…the wait time can be thirty minutes to an hour. One time I waited for two hours and a half to be seen and I was on time for my appointment, and as a matter of fact I was ten minutes early"

Jane: "The lines are so long that you know that deters you from wanting to wait. I mean wait in the car and if you standing in line that's different, but you waitin' in your car for almost two house before you get to drive through"

Laura: "We usually have to sit for like an hour-hour and half wait. That's probably some of it is that we just have to sit for so long, waiting for our turn"

Interpersonal context of food banks and food pantries. Participants also discussed how social interactions with others when visiting food banks and pantries shaped their overall experiences when utilizing this resource. Women primarily described their exchanges with food bank workers and volunteers, which, when appraised negatively, contributed to women's experiences of stigma. Eleven women detailed times when they were treated poorly or saw someone treated poorly by staff or volunteers. Many of these participants recalled that discrimination and devaluation occurred in relation to food bank or pantry workers making rude and judgmental comments toward them, using an unfriendly tone of voice, or even ignoring them, which was often described as "having an attitude":

Brittney: "Now have I had a time where I felt like some of the volunteers were little rude or you know a little pushy, yes I have had that experience. Um I don't know specifically which one but I have had that experience where um some of the volunteers are definitely a little um rude or you know can have like you know a little attitude"

Tess: "When you just ignorant, you makin' me feel like I'm dumb when I'm asking you a question about it or you just brushing me off because there's people standing behind me that need to checking in too, that's just rude…and I'll look at them and say well this will be the last time I come here and they'll be like well yeah okay yeah sure. I had one lady say yeah sure, we'll see you next month…you know not everybody comes in every month"

Lisa: "You know, it ought to be a club where you don't ask personal things or you shouldn't make comments…what if you put that person in a place where they go home and they do harm to themselves because they feel less than. You deface them and you devalue their morals and you don't know where they're coming from"

For four participants, judgement experienced was specifically related to the way that women appeared in this environment, such as what they were wearing or the car they drove. Related to women's understandings of how they are viewed by others and sociocultural depictions what a person in need should "look like", participants expressed how their own appearances were not consistent with this image, which resulted in judgement:

Lisa: "I probably don't look like I need to be at a food bank, but you know what, I have to make sure my family eats and that they are taken care of…I've walked in and um I may have a piece-I have had on a piece of jewelry and this happened more recently. Ok so you say 'Oh wow what a gorgeous ring! How can we help you?' and your tone and you're looking and then I get a couple of items. You walk out, 'Would you like such and such? Oh wow that's a nice truck!'"

Jane: "I went to one where [food bank location] and um the vehicle I was driving…and I heard one of the wo-volunteers make a comment and the said oh look at what she's driving why does she even need this food bank?"

Two women also described how they felt judged based on the body language and non-verbal behaviors of staff at the food bank/pantry:

Brittney: "They're actin' like they're impatient like they're ready for you to hurry up and things like that. Um not really that they say anything to me but it was more so just through their actions um and the facial expressions that makes you feel like-like you know they-that you're taking too long or you're doing wrong for wanting help for things"

Laura: "I would have to go to [name of food bank] and there you have to-have to, where you have to write down your income level and that you can see them roll their eyes when they look at the amount"

One participant discussed how practices of food banks and pantries involving interpersonal exchanges also led to a sense of being judged and devalued by others, such as being under suspicion of "taking advantage" of the system:

Mary: "People are not going to the food bank to make-to make money like um, um my friend told me that she had went to one and they had a read ah, ah some type of disclaimer stating that they're not going-she's not going to take the food and sell it…just degrading like why-why would I come to a food bank to-to take the money, I mean take the food, and do something else with it, like give me a break."

Intrapersonal processes informing perceptions of and reactions to stigma.

Collectively, participants demonstrated awareness of the cultural representations that underlie the stigmatization of people living in poverty. Consistent with the notion that food insecurity is just one part of a wider network of poverty and deprivation, these messages were not related to participants' inability to access food specifically, but rather the inability to meet one's basic needs more broadly. Although these messages were not specific to food bank or pantry utilization, they seemed to become activated and more salient in the minds of participants when interacting with community food banks and pantries. Moreover, women described how these representations were internalized, or "felt" (Scambler, 1998), even in the absence of negative interactions with others. Six women acknowledged how not being able to "provide" for oneself and one's family seemed to be closely tied to poverty-related stigma, indicating that people *should* be able to obtain enough food to meet their household needs.

Tess: "Another thing of being embarrassed there by going there is you had to go there like it was because you felt like you could, you should be able to maintain and do everything on your own without having to ask for help"

These statements not only reflect the societal attitude that all adult people should be able to meet the basic needs of themselves and their families without difficulty or help. Another collective assumption recognized by participants was the idea that people in need are "taking advantage" of safety net systems and resources. Six women discussed how they were perceived in this way while using community food banks and food pantries:

Jane 2: "Some places can be really demeaning basically. Cause I feel-I feel like um they're treating me like as if I'm a thief or something and I'm coming and taking advantage of a situation"

Lisa: "I don't think-I don't think there is a person that wants to just necessarily be in a line and people think it's just they're there 'cause they're getting handouts"

Tess: "Like-like people would think you're too better and they don't think that you really need the help. Like you're just going in there just to be going in there"

Six women acknowledged that people (including themselves) tend to hold certain images and assumptions when they think about the appearance of a person in need, (i.e., what a person in need "looks like"), even though people who look secure may still require assistance:

Lisa: "I probably don't look like I need to be at a food bank, but you know what, I have to make sure my family eats and that they are taken care of"

Brittney: "I said maybe my physical appearance, people I felt people looked at me in a different way um was definitely a big part of that embarrassment…Um you don't have to be certain person or look a certain way to need help"

Mary: "A person who I would think would be maybe homeless…um that's what I would think of usually when I think of someone who use-utilizing a food bank um yeah. Definitely not someone who is working everyday"

Nicole: "It's not always, like um it's not always those who just like look like struggling but other perhaps they-they look like they're okay and they're also struggling"

Eight women acknowledged that these widely held beliefs led to them being devalued by society and "seen as less than":

Laura: "It makes you feel dirty, like poor"

Mickey Mouse: "You're depending on someone else to give you something. You don't have a choice over what you get, you just have to receive whatever it is that they give you and that in itself is-it's sort of degrading"

Latasha: "It ain't what you want…you be wantin' to be eatin' like everybody else is going to eat good"

Participant's understandings of how they were seen by members of the privileged majority were closely intertwined with their past experiences and subsequent expectations of how they would be viewed and treated when using food banks and pantries. While recalling past experiences at the food bank/pantry, women also revealed their stigma-related expectations when receiving services and interacting with service providers. Overall, women's expectancies tended to be negative, reflecting the anticipation of judgement and mistreatment, and when confirmed, further contributed to participant's perceptions of stigma. Five participants talked about being viewed as bothersome or like a burden to the food pantry staff, while being treated poorly confirmed that they are seen as "less than" or inferior to those who are able to meet their food and other needs:

Laura: "Like they talk down to people, um not all of them do it but you can tell some of them do it. And it-it makes you feel inferior…and they move you like-they move you like cattle through that line"

Jamie: "It make me feel like um I'm beneath them. Like I shouldn't have to ask for something else. It make me feel like *pause* I shouldn't have came to them for their help. That I am bothering them, I'm stopping them from what they wanta be doing *pause* by asking for help"

Another expectation that emerged from interviews was related to encountering people participants knew within the food bank/pantry environment. Women discussed how "showing your face" at a food bank/pantry represented a calculated risk, as they anticipated that being recognized by people they know from other areas of their life (e.g., acquaintances, co-workers,

neighbors) would be met with judgement, disapproval, and loss in social status, rather than understanding and sympathy:

Nicole: "Um, I think, not always intentionally, but sometimes unintentionally people to, they come to judge you and again when you go and pick up these items and these things, whether they require the referral or not, um it'll you have to show your face so it's a little embarrassing at times"

Tess: "One of my church members works for [name of food bank] …and I felt embarrassed when I go up there because I know she knows me because we go to the same church. And it's just seein' people that know that you-that they don't think you would need to be there. It's embarrassing, it really is"

Two women described how these expectancies extended beyond the food bank/pantry environment, discussing how the boxes in which food was delivered to their homes (visible to neighbors) served as a stigma-related cue that influenced their level of identity threat:

Mickey Mouse: "I asked them to put it in bags versus just giving it to me in a box, um *pause* because if you get it in a box, everybody knows where you've been… you put it in a bag, nobody really knows"

Lisa: "Ah like the lady when she came out, the other week who came out, she-stuff was in Aldi bags and it was like ok that's Aldi being delivered…you don't get the embarrassment from your neighbors for seeing that you're-that a food bank is bringing you food"

Ten women described how they felt obligated to ensure their family had enough to eat, even at the expense of their own needs and health. Women viewed their ability to provide for their family (particularly their children) as a core duty and obligation related to food insecurity:

Tess: "I will do anything and everything to make sure my family eats"

Jane: "I'm going to do that first. Feed my family"

Debo: "When I went out of business, I-I was going to the churches and stuff until I got a job and got myself together so *pause* there was time, but I would um not let my kids know when I did it…until I got myself together and I finally got me a place, finally got me a real job and I said I'd never let them-never feel that, you know, that hunger again"

While visiting food banks/pantries helped women secure important resources for themselves and their families, twelve participants described how simply receiving services within this environment served as a powerful reminder to women of their inability to provide for themselves and others, representing one instance of how participants' needs-related goals have been thwarted within the larger situation of poverty and deprivation. When women perceived that they were unable to meet these goals in some way, they believed they had failed in their role:

Genie: "I mean it just sometimes it can make you feel like you're inad-inadequate, like you can't you know do something. I mean, you know, as far as making sure your family is fed properly. Um or make you feel like your um sometimes *pause* less than of a person because it's not, you know, you can't provide so yeah"

Lee: "My-my pride gets in the way and so I guess I be-kinda get stand-offish. Because I have like-I don't feel like-because I be feelin' like I should be doing more, but I'm just in a situation where I can't"

Jane: "I feel embarrassed, I'm going there that I can't provide for my family. That I have to ah seek some kind of help and something from somewhere and then you get there and the-the people make you feel like you know I shouldn't be there or I-I shouldn't need that"

Overall, interviews demonstrated that cultural representations, past experiences and situational expectations, and needs-related goals that women brought to their encounters with food banks/pantries shaped the meaning of interactions that occurred within this context. Consequently, these factors informed the degree to which participants perceived stigma and experienced its consequences. This was particularly evident for participants who were newer to the experience of using food banks and pantries in Charlotte. For two women, the stigma-related social harm risked by using a food bank/pantry seemed to be particularly salient when visiting for the first time, as they viewed the need to utilize such a resource to be incongruent with their identities:

Mary: "So we had to visit a food bank which was extremely embarrassing 'cause we've never had to visit one before"

Lee: "When I first started going to the food pantry, Like I was really like-I was really like um embarrassed to go. I was just like-I was asking a lot of somebody…I was so used to being able to do it at one time with no problem and then all the sudden things changed then it's-it's not the same anymore…it's not just a physical change, it's a mental change"

Women described experiencing a range of negative and relatively automatic emotional reactions to perceptions of stigma while using the community food bank/pantry. These shifts in emotion and arousal seemed to occur in response to esteem loss and social devaluation. Fourteen women expressed feeling a sense of embarrassment, shame, and/or guilt when visiting to food pantry:

Amy: "Yeah like when I get there I-I feel embarrassed you know, that's just like my anxiety you know like kicking in. That's really why I get like that is because I get like I feel embarrassed and ashamed"

Lisa: "You can feel shamed, you can feel embarrassed. Um people and myself have had my feelings hurt"

Seven participants also expressed a sense of disbelief, confusion, and dissonance around their self-concept and the reality of their situation.

Mickey Mouse: "I mean *pause* probably like everybody else you're just-you wonder how did we get to this place where we're have to depend on food banks and you know running out of food"

Mary: "I felt like I wasn't good enough, I felt like ah, you know, I went to school, I went to college, I did all these things, I shouldn't be, you know, waiting in-waiting in a food bank for food, you know, it's just very sobering"

Amy: "That's really why I get like that is because I get like I feel embarrassed and ashamed like how did I end up needing help? If that makes sense"

Eight women described feeling depressed, sad, or disappointed when using the food bank or pantry:

Jamie: "Ah more depressing. *pause* Um *pause* It make me feel like *pause* they're not trying to tend to my needs…It, it makes me feel like, um hard to explain. It's very depressing, it make me feel like um I'm beneath them"

Amy: "Yeah I get depressed. But if it's-if it's not enough, I-I get depressed"

Jane 2: "Sad, sad that I have to-to-to utilize this resource…Um that um I can't provide with my family"

Another emotion that participants frequently endorsed was frustration. Eight women explained how visiting the food bank/pantry made them frustrated and aggravated:

Jane: "It-it it's hard, it's aggravating…they want to know your income, I got to explain to them why I'm out of work. They want to know why, was I getting-was I getting this, was I getting that. Um yeah…that's the frustration "

Tess 2: "You're frustrated 'cause you got to stand in a line and you know that they're only going to take so many numbers at-on this particular day. Hoping that you get there in time enough before all the good stuff get gone"

Four women reported that they felt intimidated or scared by the experience of visiting the food bank/pantry:

Mary: "The fact *sigh* that I had to actually search out a band and actually search and actually go somewhere and, you know, just all that-just the whole- you know, just the whole process was very intimidating"

Jamie: "I just feel very intimidated when I go. But um, it's hard to explain *pause* uh they make you feel less than human"

Six women also found the experience of utilizing the food bank to be stressful or anxiety provoking:

Lee: "So stress, it makes you feel stressed and frustrated at yourself really because now you can't do what you wanted to do or what you were able to do at one time"

Amy: "It makes my-it makes my anxiety go up…I get nervous, kinda like how I am on the phone conversation. But it's like my anx-anxiety like really kicks in…I don't like asking for help…You know, I get nervous, I start shaking"

Additionally, participants described feeling angry (Debo, Lisa) and leery of the organization's intentions (Jane 2). Although participants predominantly emphasized their initial emotional reactions to perceptions of stigma in the food bank/pantry context, they also described their intentional use of coping responses in order to manage threat and negative emotion. Cognitive-based strategies employed by women seemed to serve the functions of reducing loss of esteem and promoting positive self-concept in light of emotional distress. Thirteen participants described how they were able to put their experiences of stigma and interactions with systemic barriers into perspective by considering the level of deprivation they might experience without using this resource. They were able to rationalize encounters with poverty-related stigma and systemic barriers because they ultimately were able to obtain some usable food resources for themselves and/or their families, enabling them to fulfill their role as providers (even if only partially). Because they were able to meet this goal, women discussed needing to express gratitude for whatever food they received, despite the hardship they may have gone through to receive it:

Jane 2: "It helps. Um but um no it doesn't meet the need but it helps…I mean something is better than nothing as far as I'm concerned"

Laura: "You kind of overlook a lot of things but you know you can see they way they're treating other people too…it's one of those things where you know, if you do speak out, you might not get the help, any help, so you try to be grateful for the help that you're getting"

Lee: "At the end of the day I have to understand that I have to make or provide somehow so if that's the way that I can provide it's-it's something"

Latasha: "It's like, you getting's stuff when they have stuff that they give you but you really-you don't even want it because you just-you don't like that but then some of it is ok, some of it's not, but then you can't be choosy with it like they give you something, you still have to be thankful that they give you stuff because some people don't even have that…like it's not what you really want but there's something there to keep you going from day to day"

Genie: "You can't complain about it. You just get it and use it"

However, four women discussed how experiences of stigma caused them to question the utility of continuing to use community food banks and pantries as a resource:

Jamie: "Sometimes I'll, I'll need to go to the food bank but once I think about uh some of the bad experience I have, I've-I've change my mind and try to think of something else though…It make me have second and third thoughts about going back"

Debo: "Ah I-I mean I appreciate it, but you know um for all the information they got it wasn't really worth it"

Many participants described using what researchers label as "cognitive reframing" (Vernooij-Dassen, Draskovic, McCleery, & Downs, 2011) to gain a new perspective of themselves and their current situation. Specifically, seven participants were able to acknowledge that there are larger social and cultural forces at play of which many people are ignorant, describing how people "don't know my situation". This realization enabled them to contextualize their experiences within the realities of systemic inequity and others' unawareness of it:

Jane 2: "I think people judge, they don't know, I mean, they just don't know like your whole story…they don't know how long you've been outta work, they don't know, they just think you're some little story"

Laura: The [name of food bank] lady, she would ask- it seemed like to-it sound like she was picking on me cause I had to write down your income I would write down 15,000 and I-I'd look at it and I'd be like nobody else has that amount. Why am I here? I mean it's really not that much more when you-when you think about how much it costs to live"

Lisa: "We put out a lot of money a week, my FSA is gone, so when I pull up or and I'm limping, or I'm in excruciating pain and I'm saying okay I put-I got 200 dollars for my bills this week, I need a little bit of help this week buying my deodorant, my this, don't judge"

Sasha: "Everybody doesn't know your situation, you know, you see these people and you don't know what they're going through… even people two-family households with two parents working that still experience um you know maybe needed food or you never know what someone is going through, so I try to look at it like that"

Four women also used their understandings of common humanity and hardship to justify their inability to fulfill their role as food provider at this time, recognizing that difficulties can happen to anyone:

Nicole: "I feel like anybody can-can struggle…and ah I feel like emergencies too can, ah I feel like emergency crisis can come to anyone um…I feel like um like you can like it can happen to anyone"

Lisa: "Hardship happens. How long does it last, we don't know. But it-it's happening and I think that people that *pause* don't want to go but need to go, need to be made assured or at least feel like it's ok"

One participant engaged in what other researchers have termed "cognitive distancing" from other people living in poverty (Reutter et al., 2009) in order to protect her self-concept. Specifically, she discussed how her current financial situation and associated stigmatization is only temporary due to COVID-related job loss, whereas for others it may be more enduring:

Mary: "It's not my fault that we're in a pandemic so I just have to keep reminding myself of that…because I know good things are around the corner and I know that I won't you know, I won't have to use this food bank anymore so after this so it should be good"

Seven participants spoke about how they changed their behaviors to reduce the negative emotional consequences of utilizing safety net services. Related to having "second and third thoughts" about using food banks and pantries, these women discussed how they (and others) have attempted to avoid food banks and pantries altogether to safeguard their self-esteem and social identities, with varying levels of success. While some participants were able to qualify for and pursue alternative food safety net opportunities, others had fewer options:

Lisa: "There's a lot of people out there that pride will supersede the need for them. They won't go or they don't like to go because they feel shamed"

Jane: "I did call and complain to [name of food bank] and told them but I mean you know I know they are volunteers, so you know um. The only thing that I haven't called there to go. And I wouldn't. And I wouldn't refer anybody either"

Debo: "Always appreciate what I get from them but like I said I stopped dealing with them because of the fact like I said you have to give your life story... I'll go to the churches and they give out the same thing"

Jamie: "I end up going back because I don't call other people to see if I can get help from them and the only, the only other choice I have is to go back to the food bank"

One participant provided insight into a powerful way people may be able to protect their self-esteem while still utilizing food banks and pantries: advocacy. Lisa described how she advocates for both herself and others, recognizing that while she is able to endure these experiences using her resilience, some people may not be as well equipped:

Lisa: "I'm an advocate of speaking up not just for myself but for others. Do you know how you might have made that lady feel...Are you saying that to everyone? And when the lady tells me, for me, I just make a comment. I go-I go on the website or I see what the contact information and I say I went on this particular day, to this particular location, and this happened to me or this was said. I want to um let you know this because I handled myself but what would someone else do in that circumstance and how does it-how would it make another person feel…people need to be an advocate for people 'cause you don't know what they're going through or what they need"

Utilization of Food Banks & Food Pantries: Suggested Improvements

All participants suggested ways in which food bank and food pantry services might be improved to better meet the needs of people experiencing food insecurity in Charlotte. The majority of women's recommendations were directly related to systemic barriers faced when attempting to access and utilize the food bank. Consistent with the transportation and physical burden-related obstacles participants encountered when using food banks and pantries, nine participants recommended that more organizations offer delivery services and/or transportation assistance.

Tess 2: "Sometimes we're really concerned about getting there but nobody really takes the time to understand how-what happens once we at home but how are you getting home? Maybe some food pantries need to offer more delivery and I know that's a lot to ask. You know um, but *pause* it's-it's got to be worked out, that's the way, you know what I mean?"

Brittney: "I definitely feel like more pantries should be able to do that especially with some-some people not having transportation um so definitely if maybe they can do like a delivery service or something if they're not able to come and pick it up"

Sasha: "Maybe like if you know some of them would have, you know for my church they pick up the elderly and they actually bring them…bring them the ones that can't get out"

Nicole: "Well just earlier I was looking to see if there is like gas like assistance…again it's not like it um is super close by"

Six women suggested that food banks and pantries in the Charlotte area reform the referral process to require less private information:

Lisa: "I think that the application process shouldn't-it shouldn't be so in-depth…and the referral thing stinks too for a lot of people because again you don't know, you shouldn't have to go thought social service or whatever they call it now to get a referral"

Lee: "I think it would be easier for a lot of people to get the food who need food if there wasn't so much documentation needed"

One participant called for the referral process to be abolished altogether:

Tess 2: "I think in a sense if that referral process is done away with and it's just done…then you would eliminate that process of even having to be in that little stressful situation that you don't want to go through the referral process to get the food…get rid of that referral process"

Additionally, participants made several suggestions to improve aspects of the food items received from banks and pantries. Seven participants suggested that food banks and pantries provide more variety in the foods that they offered, such that food items received were more appropriate and relevant to the individual's lifestyle:

Genie: "If they were able to get fresh fruit um and vegetables, um and if they can provide, I guess like *pause* a little more meat"

Mickey Mouse: "Um maybe if some of the-the food banks um had meat and not just canned good…things that people use to cook with, everybody doesn't necessarily or just eat canned goods all the time"

Tess: "Put up more options like the milk thing, if they don't have real milk, you know and like not everybody can drink the dry milk"

Seven women also described how food banks and pantries could provide better quality and greater quantity of food to meet their needs:

Nicole: "Some of the items they're not like the-the best um best items but it still helps…I wish they kinda weren't expired"

Jane 2: "Something where they can offer um more fresh foods um *pause* I mean we're really talking about an impact on our health, um we need to be able to have, you know, fortifying foods and um access to fresh fruits and vegetables"

Brittney: "I mean if it is possible giving more food um…you know, to last um for you know like the whole month"

Four participants suggested a need for a greater communication and visibility of information related to available food bank and food pantry resources, as many people in need may not be aware of existing services:

Laura: "I know there needs to be an information site that- a good one… you know if there was a coordinator like you can just talk to on the phone for all the food banks, that would be really awesome"

Jane 2: "Just getting the word out is key. Um that's what I do when I can. So sometimes there's things that people just don't know about that's available…I-if there is one that I don't know, but also don't know how to go about seeking those resources out either"

Lisa: "It needs to be a little bit um more informative, information for people, whether it be on the internet, broadcasting"

Other barrier-related recommendations to improve food bank and pantry services included providing gift cards or grocery vouchers (Tess, Latasha), rescuing leftover food

resources from restaurants and events (Lisa), training and vetting volunteers (Lisa), and having a suggestion box (Tess 2).

More closely associated with the stigma processes described previously, seven participants suggested that food bank and pantry workers interacting with individuals experiencing food insecurity could be doing more to create a hospitable environment in which people can access food. Specifically, women talked about how workers could use more "encouraging words" and show more kindness towards visitors at the food bank/pantry:

Jamie: "Be friendlier to people. I mean because it's like they-they don't like socialize with you. It's just, it's like, they-it's like, they want to hurry you in and hurry you out…and if they just speak friendly to you. I mean if they just give you encouraging words, I mean that will make a person's week"

Mary: "I would say *huff* just be cordial to people."

Amy: "I was going to say like after the small talk and the conversations it-it makes everything so much better. You're nervous at first but after a little small talk…you know, it-it makes it easier"

Finally, consistent with barriers related to the acceptability and variety of food, four participants expressed a desire for more choice and control over what foods they received from food banks and pantries:

Jane 2: "Um they could-they can um collect information on what it is that I need…where they can see okay well we have this, and then I can select what it is that I need…like actually ah doing some shopping you know?"

Mickey Mouse: "Sort of maybe talk to you for a minute, you know say 'ok Is there anything you specifically need' and if they have it, then they can provide, and if they don't that's understandable, but at least ask you, give you a choice instead of just giving you something, something that you don't even know what it is and something you can't use"

Tess 2: "I think being able to decide what you eat to somewhat degree is very helpful because one we're not wasting extra food. How many times I-I've now had a can in the cupboard maybe fore about four or five months and I'm wondering, 'Am I ever going to eat that?' Probably not"

Researcher statement and reflexivity.

In accordance with the constructivist grounded theory approach, I engaged in reflexivity (Findlay, 2002) throughout the study process, considering how my background, identities, education, and lived experiences have shaped this research. Predominantly, my identity and training as a student researcher in psychological science has strongly influenced the methodology, analysis, and rigor of the current study. Specifically, emphasis placed on the cognitive, affective, and behavioral responses to stigma (and their implications for health) is grounded in my specific training as a health psychologist, while the constructivist grounded theory approach taken in this study reflects my broader interdisciplinary training as a social scientist. Simultaneously, however, my identities and experiences as a "Charlottean" and food bank volunteer also strongly influenced the approach and direction of this research, and my research interests more generally.

Having spent the majority of my life in the Charlotte metropolitan area, I care deeply about the health, welfare, and wellbeing of the members of my community. Growing up, I learned about (but did not experience) the legacy of systemic, racialized inequity and division of power that has prevented upward mobility of families in Charlotte for generations, while leading to pockets of extreme poverty just beside areas of tremendous wealth. In my community work with my synagogue, which involved volunteering at Urban Ministries and local food banks/soup kitchens, I began to see firsthand the connection between these historical socioeconomic disparities and the health and wellbeing of individuals living in my community. Conversations with community members revealed to me truths that a textbook never could—the chronic stress and emotional strain of deprivation, the stigma and isolation associated with "being poor", the intersections of social and economic status with gender and racial identity and how this impacted self-worth, and navigating the healthcare system in light of the economic disadvantage that

shaped so many of these health concerns. As I got older, I came to understand that, if I wanted to truly make an impact, I needed to act as an ally and advocate, in both my professional and personal lives. Thus, consistent with my experiences, values, and beliefs, I not only feel that I have a responsibility to place my interest in psychology within the broader context of social and economic need, but also take on a strength-based, empowerment perspective that amplifies the voices of those who have been historically silenced and uses an action-oriented approach to address real world inequity.

Importantly, throughout this process I have reflected significantly upon my own privileges and how this has impacted my reactions to and interpretation of the data. I have never experienced food insecurity or poverty in my lifetime and am not only economically privileged but also privileged in terms of my racial identities and educational background, which has allowed me to benefit from the inherently oppressive systems and structures that govern our society. For this reason, the perspective that I bring to this research is fundamentally etic (Pike, 1967), necessitating careful awareness of the lens through which I see this research and how I may be perceived as an "outsider" by participants. The nature of the questions asked to participants are integrally impacted by my knowledge of stigma theory, my perceptions of which key factors might be contributing to stigma within the food bank environment, as well as the words I use to describe these phenomena, and thus there is some feasibility that these questions did not elicit the full spectrum of stigma experiences. Moreover, it is possible women may not have shared certain experiences or perceptions with me as a result of my outgroup status and privilege, which might have led to perceptions that I might not be entirely trustworthy (e.g., participants may have believed I worked for the one of the food banks, even though I indicated this was not the case), or that I may lack understanding or empathy. As this area of research continues to develop, integration of more emic (Pike, 1967) perspectives will be important to

further explore and understand stigma related to poverty and how it may influence health and wellbeing.

My privilege and etic perspective became increasingly apparent as I noticed how my own disbelief and frustration with the lived experiences of participants was contrasted with their acceptance of this unfair and discriminatory reality; while the specific information shared by participants was a newer realization for me, it simply represented the truths of everyday life for the women with whom I spoke. The discrepancy between my lived experiences and the lived experiences of participants further drove my desire to become more involved in advocacy efforts associated with systemic inequity outside of the academic environment. Related to this advocacy and activism, it is also important to mention how my role with the Hearts and Hands Food Pantry developed throughout the course of the study. While I collaborated frequently with the organization's leadership frequently in working out development of the study design, recruitment, and other logistics, I also spoke with them at length regarding ways in which members of academia (such as myself) can be doing more to advocate for the populations that we study, as well as how I can help as a community member more broadly. These conversations led me to take on a volunteer role at the food pantry as an administrative assistant in December 2020 (during data collection and analysis); my work has involved contacting eligible individuals in the community and connecting them with food pantry services. Thus, I now occupy a dual role as both a student/researcher and a volunteer/advocate with respect to my work with the pantry. Gaining this "behind the scenes" perspective of how people in need are referred and processed through multiple institutions and organizations provided me with new insight into the rich accounts of participants in this study and the experiences of people like them. I believe that this experience has been and will continue to be fundamental to my development as a student researcher that aims to highlight issues of social justice and equity in my work. Furthermore,

occupying this double role has deepened my relationship with leadership of the food pantry, creating a foundation for future allyship and advocacy, whether academic or otherwise.

CHAPTER 4: DISCUSSION

The present study examined how poverty-related stigma is perceived within food bank and pantry contexts, emphasizing the narratives and lived experiences of the people who utilize these resources. Taking a constructivist grounded theory approach (Charmaz, 2006), this research explored the ways in which poverty-related stigma is conveyed in this environment specifically, while also capturing how perceptions of this stigma impact emotional and mental wellbeing, self-esteem and identity, and continued utilization of food banks and pantries. Participants' rich descriptions of their experiences provided crucial insight into the multi-level determinants of the experience of poverty-related stigma and the dynamic processes that convey these messages, representing findings that are both novel and consistent with prior research in this area. Overall, the results of this study elaborated upon the intrapersonal processes by which stigma is perceived and managed, while also supporting the findings of prior research that focuses on interpersonal and structural determinants of poverty-related stigma.

Upon initial coding and review of the present data, it was evident that there were several factors that influenced women's perceptions and experiences of poverty-related stigma within food banks and pantries, leading to a variety of emotional, cognitive, and behavioral reactions and responses. While some of these factors had been captured in previous sociological work (e.g., perceived discrimination from food bank staff; Purdam et al., 2015), other factors did not (e.g., stigma-related expectations related to the food bank context, some ways of coping with and/or resisting stigma). Moreover, gaps still existed in understandings of how these processes unfolded, as previous research and models of stigma used to shape interpretations of the data (e.g., Crocker, Major, & Steele, 1998; Scambler, 1998) did not fully capture the range of experiences described by participants. Consequently, a more nuanced perspective of these

intrapersonal processes and the mechanisms underlying them was necessitated to gain a clearer, fuller picture of participants' accounts. Major and O'Brien's (2005) model of stigma-induced identity threat provided a more parsimonious framework to interpret and understand women's experiences.

Major and O'Brien's (2005) model maintains that "stigma exists when labeling, negative stereotyping, exclusion, discrimination, and low status co-occur in a power situation that allows these processes to unfold" (p. 395). Of great importance is the perception of stigma on the part of the person being stigmatized, which represents a threat to their social identity. Indeed, this perspective considers appraisals of stigma as threats to the self ("stigma-induced identity threat") that result from belonging to a devalued social group and can engender losses to personal and collective self-esteem (Major & O'Brien, 2005; Tajfel & Turner, 1986). Appraisals of stigma and accompanying identity threat may be influenced by several factors that involve individuals' past experiences, expectations, social knowledge, and motivations, in addition to the current situation. Awareness of collective representations, or dominant views and portrayals of one's stigmatized identity (e.g., knowledge of cultural stereotypes), can influence how stigmatized individuals perceive and judge possible indicators of stigma and situations that may be stigma relevant. Moreover, previous encounters with stigma allow people to develop expectancies regarding stigma-related circumstances, cues, and contexts, which then serve as a lens through which they view situations that may potentially threaten social identity. Furthermore, personal goals and motivations may significantly shape the appraisal of identity threat in a situation. In particular, the motive to "protect or enhance" self-esteem, as well as maintain other identity-related beliefs and schemas have been explored previously in social psychology research (Major & O'Brien, 2005, p. 401). While the factors that inform appraisals of stigma in a given situation may vary considerably between individuals, the process of identity threat activation is uniformly

nonverbal, automatic, and occurs outside of conscious awareness. Once a person experiences a stigma-induced identity threat, they may undergo a variety of involuntary responses, including emotional and physiological stress reactions, such as anxiety and heightened vigilance for threat-related stimuli, in addition to losses in self-esteem. As a result, individuals may cope with identity threat through a variety of voluntary responses to manage the negative arousal and emotional experience resulting from stigmatization (Major & O'Brien, 2005). Coping may involve cognitive, emotion-focused, and behavioral strategies that may result in disengagement with identity-threatening situations, domains, and contexts (Major & O'Brien, 2005; Miller & Major, 2000).

Consistent with Major and O'Brien's (2005) conceptualization of social stigma, stigma relating to poverty and food insecurity may constitute a significant threat to the social identities of individuals who are unable to meet their needs. Seeking out and receiving services from food banks and pantries represent situations in which stigma may be perceived and identity threatened, based on individuals' cultural knowledge, needs-related goals, previous experiences, and expectations relating to these contexts. Importantly, interactions with these safety net services have the potential to result in losses to self-esteem and psychological wellbeing for the individuals who experience stigma-induced identity threat when using them. The motivation to "protect and enhance self-esteem" may lead to avoidance of and disengagement with these stigmatizing experiences, at the expense of meeting food- and diet-related health needs (Major & O'Brien, 2005). Despite potentially safeguarding psychological wellbeing in some ways, disengagement with safety net services hinders access to and use of food resources, which may not only confer risk for developing health problems, but also worsening existing problems and progression of disease (Gundersen & Ziliak, 2015). Thus, this model supports and explains how stigma related to food insecurity and food safety net service utilization may represent an

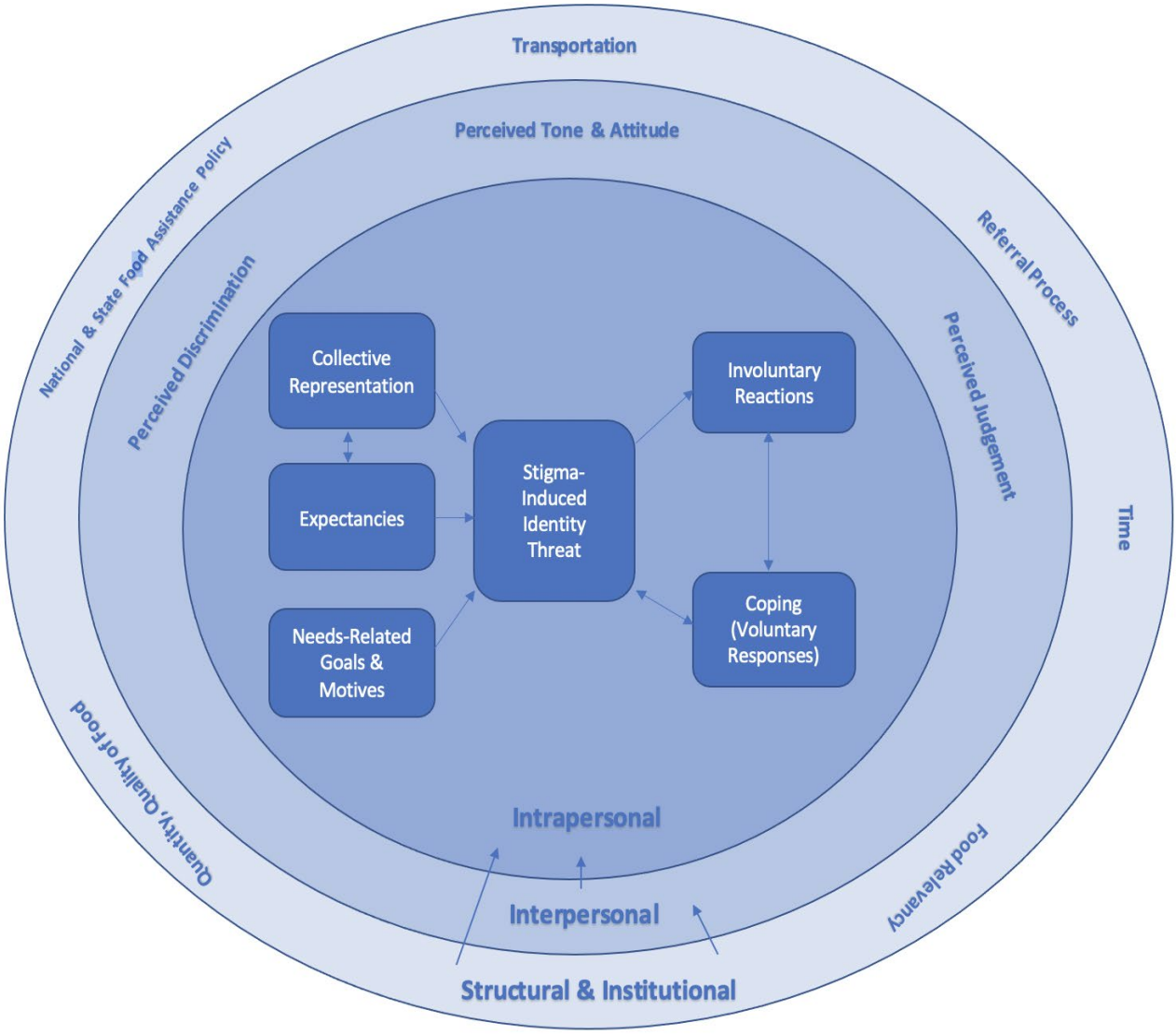
insidious barrier to health and food access by threatening social identity and self-esteem, ultimately discouraging the use of such services to sustain healthy living. Application of Major and O'Brien's (2005) theoretical considerations, as well as prior research in this area, to interpret and understand the present study's findings are explored next with the conceptual model.

Conceptual Model.

The conceptual model based on this study's results offers the first organizational framework reflecting the concepts and processes relevant to perceptions of poverty-related stigma in food banks and pantries (Figure 1), representing a critical starting point for further exploration into how poverty-related stigma is experienced in a variety of environments related to needs assistance. Specifically, the conceptual model was informed by contextualizing participants' narrative accounts within knowledge and theory gleaned from prior research; this model integrates aspects of Major and O'Brien's (2005) model of stigma-induced identity threat, Link and Phelan's (2001) sociological perspectives on stigma, and Bronfenbrenner and Ceci's (1994) bioecological model of human development to provide a focus on interpersonal and structural factors influencing stigma processes. The concentric circles represent the multiple contexts in which stigma processes are unfolding, consistent with Bronfenbrenner and Ceci's (1994) ecological perspective. The outer circle reflects the structural and institutional conditions that shape participants' experiences of stigma, highlighting the multiple barriers that participants described encountering as they attempted to meet their needs. The middle concentric circle represents the interpersonal and relational circumstances that also influence stigma-related experiences, such as interactions with staff, volunteers, and other people using the food bank/pantry. The word "perceived" is used here to reflect the importance of the individual's appraisal of discrimination and judgement, as it is this perception that fundamentally informs the experience of being stigmatized. This is detailed within the inner concentric circle, which

illustrates the intrapersonal context; the dark blue boxes depict the psychological processes that inform perceptions of stigma and identity threat, as well as how this threat is managed, consistent with Major and O'Brien's (2005) model. Using this framework to understand women's lived experiences of stigma within food banks and pantries, women's appraisals of stigma-induced identity threat were influenced by 1) their understandings of cultural knowledge and collective representations of people who use food banks/pantries, 2) their expectancies and anticipation of stigma in this context, informed by past experience and stigma-related cues, and 3) needs-related goals and motives, such as providing for oneself and one's family. Furthermore, stigma-induced identity threat resulted in involuntary reactions, such as shame and anxiety, which further led to coping responses and efforts to reduce negative arousal and self-esteem loss, like cognitive reframing and behavioral avoidance.

Figure 1. Conceptual model illustrating study findings.



Integration of Results with Previous Research and Theory

As observed in prior research conducted in the U.K. (Garthwaite, 2016; Purdam et al., 2015), this study demonstrated that there are significant systemic barriers associated with the utilization of food banks and pantries. Overall, participants described numerous structural barriers related to accessing and utilizing local food banks and pantries, illustrating a network of difficulties unique to the food bank/pantry context that individuals face as they attempt to meet food and other needs, illustrated in the outer circle of Figure 1. While similar barriers have been ascertained in previous stigma-related research in the U.K. (Garthwaite, 2016; Purdam et al., 2015), the referral process, need for transportation, as well as inadequate relevancy of food provided, represent a collection of barriers that may be distinct to the landscape of food safety net resources in the U.S. These barriers are reflective of the ways in which existing systemic and institutional practices and policies, in addition to control over and selective distribution of food resources, contribute to inequalities in food security. Moreover, consistent with previous studies, the current research found that these barriers inherently shape the experience of poverty-related stigma in the food pantry context. Such systemic obstacles not only characterize the experience of accessing and utilizing this safety net resource, but also support the circumstances under which stigma is perceived and felt, suggesting that these structural factors influence intra- and interpersonal processes (represented by the arrows connecting the outer and inner concentric circles of Figure 1). Thus, identifying barriers to utilization that contribute to perceptions of stigma is particularly important to gaining a better understanding of how food banks and pantries may modify procedures and the physical environment to create a more positive, empowering experience for people who use these resources.

In addition to structural and institutional factors, prior research has also emphasized the importance of interpersonal interactions in perceptions of poverty-related stigma (e.g., Reutter et

al., 2009). Specifically, previous research has explored instances of discriminatory treatment directed towards people as they attempt to seek services from a range of other safety net organizations (e.g., accessing federal benefits or SNAP; Collins, 2005; Reutter et al., 2019). In the present study, women's accounts indicate that these stigmatizing interactions extend to the food bank and food pantry context as well, represented by the middle concentric circle of the model depicted in Figure 1. Indeed, participants' experiences using food banks and pantries demonstrate that stigma-induced identity threat in this context is characterized by unfair or unequal treatment (i.e., "enacted" stigma; Scambler, 1998), that confirmed women's stigma-related expectancies. In addition to discrimination, accounts provided by participants further evidenced that identity threat was experienced in response to perceptions of judgmental attitudes, body language, and expressions from others, expanding upon the literature in this area. Overall, these findings echo those of prior research while also demonstrating the importance of nonverbal aspects of interpersonal interactions that occur in food safety net environments.

The current study predominantly focused on understanding the intrapersonal processes that informed participants' perceptions of and reactions to poverty-related stigma within food banks and pantries, represented by the inner concentric circle of the conceptual model in Figure 1. Taking this psychological perspective, the present research was able to elucidate and contextualize these processes within broader interpersonal and structural conditions in order to better understand how stigma influences health; the influence of these conditions upon intrapersonal processes is depicted by arrows drawn across the concentric circles in Figure 1. Collectively, participants' accounts were largely congruent with models of social stigma and identity threat (e.g., Major & O'Brien, 2005), in addition to prior research examining stigma in safety net environments. Several processes informed women's individual appraisals of stigma-induced identity threat, illustrated in the center of Figure 1, largely consistent with Major and

O'Brien's (2005) framework. Interviews demonstrated that participants had significant cultural knowledge related to the ways in which people who utilize food banks/pantries were seen by society. These collective representations encompassed distinct beliefs, attitudes, and even images that reflected participant's understandings of broader systems of social status, power, and control over resources. These findings corroborate that stigma not only refers to social labels assigned to human differences (Goffman, 1963), but also captures the structures in place that enable and sustain inequity and discrimination (Link & Phelan, 2001). In particular, women recognized that there is a particular, shared cultural image or "look" associated with someone who needs to use a food bank (e.g., someone who appears to be homeless) and seemed to internalize these sociocultural views. Women discussed how their own appearances did not seem to fit with this assumption, which led them to be judged by others. Women experienced dissonance between the way they appeared to others and their actual need for assistance, with concerns that if they did not "look poor" enough, others may assume they are taking advantage of this resource due to this discrepancy. While not explored in the current study, cultural agreement on a specific "look" related to experiencing poverty may be in part due to media representations of "the poor" (e.g., "poverty porn"; Garthwaite, 2016). These findings suggest that what society expects someone in need to "look like" facilitates experiences of stigma regardless of whether or not the appearances of real-life people who utilize food banks and pantries match this expectation. Participants' interviews also evidenced how their individual needs-related goals and motivations impacted how they perceived stigma relating to poverty and food insecurity. In particular, identity-driven motives related to women's need to "provide" and their roles as mothers and caregivers had a strong impact on women's self-concept and appraisals of identity threat.

Moreover, consistent with psychological theories of stigma and its effect on social rank and self-concept, this study exemplifies how the appraisal of stigma leads to identity threat, loss

of self-esteem, and devaluation of one's social status (Crocker, Major, & Steele, 1998; Major & O'Brien, 2005), evidenced by women's shame and humiliation. Participants' experiences of stigma-induced identity threat were generally congruent with other studies investigating stigma within the context of food banks and food pantries. For instance, women's accounts of being seen as "less than" as a key part of experiencing stigma are in accordance with Garthwaite's (2016) observations of "othering" in the food bank context. However, the current research expands upon these previous findings by offering more nuanced perspectives of how this experience of stigma-induced identity threat contributes to a range of involuntary reactions and voluntary coping responses. Specifically, in addition to feelings of embarrassment and shame, considered to be core emotional responses to social threat (Kemeny, Gruenewald, Dickerson, 2004), women also expressed frustration, stress and anxiety, intimidation, and anger as they interacted with food banks and pantries. These emotional reactions were largely consistent with the accounts of people using food banks and pantries in the U.K., who similarly indicated embarrassment and shame were central to their experiences of stigma in this environment (Garthwaite, 2016; Purdam et al., 2015). Women also used cognitive coping strategies to manage identity threat in response to stigma in the food bank context. Women were able to reduce identity threat by reminding themselves of their needs-related goals (e.g., "something is better than nothing") and contextualizing their experience using common humanity (previously observed by Garthwaite, 2016) and knowledge about pervasive inequity ("hardship happens"). For some women, the experience of stigma led them to have second thoughts about using the food bank or pantry, evidencing a form of resistance in which women considered the value of avoiding a stigmatizing experience altogether to protect their identity and self-esteem.

The behavioral implications of experiences and perceptions of poverty-related stigma were also explored in this research. Importantly, the current study demonstrates that stigma

indeed does serve as a barrier to food bank and pantry utilization by having a negative effect on self-esteem. In an attempt to "manage" the adverse impact of stigma (Goffman, 1963) and safeguard positive self-concept (Major & O'Brien, 2005), social avoidance of stigmatizing contexts such as food banks and pantries (also observed in Garthwaite, 2016) may be protective in some ways, and harmful in others, particularly when considering the possible health effects of forgoing food safety net resources. A meaningful behavioral response to stigmatization that came up in this study was advocacy for both the self and others, which has been observed in other research focusing on the experiences of stigmatized groups (LeBel, 2009; Valente et al., 2020). One participant described how she was able to protect and enhance her positive self-concept by demanding respect, speaking up when she noticed unfair treatment occurring, and reporting discriminatory incidents to organizations. Previous research focused on poverty stigma more broadly has demonstrated how helping other people in need (i.e., volunteering themselves) may promote greater esteem by fostering a sense of efficacy and agency (Reutter et al., 2009); thus, the present study extends these findings to include other forms of advocacy and resistance. Indeed, prosocial in-group and advocacy behaviors may represent actionable responses that cultivate a greater sense of empowerment and restore self-esteem, however more research into how these approaches might promote health and wellbeing within a stigmatizing context is needed.

Prior research (Purdam et al., 2015) has captured some of the ways in which people attempt to meet their food needs while living with needs insecurities (e.g., budgeting, rationing food); the current study corroborates the implementation of these strategies, while also shedding light on other methods by which people navigate a landscape of uncertain food resources. In addition to the strategies mentioned in Purdam et al. (2015), participants described frequenting churches and soup kitchens, enrolling in SNAP or WIC, and even "going without" in order to

make ends meet. These perspectives support the notion that no resource available is sufficient to meet all of the needs of individuals living with food insecurity, requiring people in this situation to make use of a variety of potentially esteem-altering strategies to obtain food.

Consistent with participants' desires for greater control and choice over the food they receive, sharing, trading, and bartering food may represent one way by which individuals living with food insecurity may increase their level of agency in a situation where there is very little, while preserving a positive sense of self. Food agency (Trubeck, Carabello, Morgan, & Lahne, 2017), is a relatively new concept in the literature on food purchasing, cooking, and eating behaviors. Food agency refers to the degree to which individuals "are empowered to act throughout the course of planning and preparing meals within a particular food environment" (p. 298). It describes how people plan, access, obtain, prepare, and consume food within intricate individual, cultural, and social contexts, and emphasizes not only one's ability, but also their empowerment to do so (Trubeck et al., 2017). Thus, increasing the level of food agency for those who utilize food banks and pantries by giving people more choice and control over what food resources they receive, as well as enabling people to trade and exchange items freely, may represent one way by which self-esteem can be protected while fostering a sense of empowerment within this context, ultimately leading to greater accessibility.

Importantly, the current sample consisted of only female-identifying participants. While the reason for the sample's homogeneity in terms of gender is unclear, it may reflect the fact that women tend experience food insecurity at higher rates than men (FAO, 2017; Jung, Souza de Bairros, Pattussi, Pauli, & Neutzling, 2016) and women in U.S. South often take on the gendered role of purchasing and obtaining food for their families (Freedman, Blake, & Liese, 2013). Consistent with this fact, according to pantry data, approximately 85% of clients of the Hearts and Hands Food Pantry identify as women. Additionally, about two thirds of the sample

identified as people of color, consistent with longstanding racial disparities in food security in the U.S. (Coleman-Jensen et al., 2019). Consequently, it is important to consider how the results obtained reflect the experience of poverty-related stigma for women specifically, as well as their intersections with race and other diverse identities that may influence perceptions of stigma. Findings demonstrated that the ability to feed one's family was of critical importance to the majority of participants, consistent with previous research evaluating how women experience and manage food insecurity (Papan & Clow, 2015) as well as the gendered division of household economic responsibilities and allocation of food resources (Ivers & Cullen, 2011). Moreover, the accounts of women who participated in the current research underscore that the motivation to "provide" not only for oneself but for one's family, including children, partners, parents, siblings, and other people in the home, may supersede the motivation to promote and preserve one's health and self-esteem; these findings are consistent with gender socialization and highlight the demands associated with one's gender role in the household (Martin & Lippert, 2012). Furthermore, women's experiences of food insecurity reflected the impact of deprivation on both their physical health and their mental/emotional health, corresponding with past qualitative research focusing on African American women's perceptions of food insecurity and health, distinguishing between "hunger of the body" and "hunger of the mind" (Chilton & Booth, 2007).

Strengths and contributions.

The current research offers several contributions to the existing literature examining stigma related to poverty and food bank/pantry utilization. The present study adds value to the known association between stigma and health by exploring narratives related to poverty-related stigma within the context of food insecurity, which have been left out of quantitative research. The current study also provides an incremental contribution to the qualitative stigma literature by

investigating how the specific need for food influences relates to poverty-related stigma, and how food safety net services contribute to perceptions of and reactions to this stigma. Additionally, expanding upon previous research examining poverty-related stigma and food insecurity in the U.K. and Canada, this study offers new insights into how stigma may be perceived and experienced by people who utilize food banks and pantries within the unique food safety net landscape of the U.S.

Moreover, this study used an intrapersonal lens to bring greater understanding to participants' narratives, drawing upon psychological theory of stigma (e.g., Major & O'Brien, 2005) to guide understandings of how poverty-related stigma was perceived, felt, and coped with. Likewise, results were integrated with the structural and interpersonal findings of previous ethnographic and sociological research, contributing a more comprehensive understanding of how food insecurity and associated stigma inform how people experience and manage these lived realities, with implications for their health and wellbeing. The conceptual model produced by integrating psychological theory and prior knowledge with participants' narrative accounts is a significant contribution of this research, offering the first organizational framework reflecting concepts and processes relevant to perceptions of poverty-related stigma in food banks and pantries (Figure 1). This model represents a critical starting point for better understanding and further exploring how poverty-related stigma is experienced in a variety of environments related to needs assistance in future research.

Furthermore, the current study took several steps to strengthen the overall authenticity, credibility, dependability, and transferability of qualitative findings (Lincoln & Guba, 1985), offering qualitatively rigorous evidence for the conceptual model presented. Importantly, the constructivist approach (Charmaz, 2006) taken in this research bolsters both the theoretical and practical utility of the present findings. Allowing participants to take an active role in the co-

creation of knowledge throughout the research process facilitated accuracy of data interpretation and trustworthiness of the findings presented, while challenging researcher bias. Participants' and researchers' contributions led to the construction of a conceptual model that both integrally captures the lived experiences and perspectives of a population historically underrepresented in research and contributes meaningfully to existing empirical understandings of poverty-related stigma. The constructivist tradition of this research also encourages actionable changes that are relevant to needs of the communities that utilize food banks and pantries, as the recommendations captured in this study are directly informed by community members' experiences. Specifically, women's suggestions regarding how poverty-related stigma can be reduced within the food bank/pantry environment will be disseminated to community food banks and pantries. Both researchers and participants hope that these recommendations will lead to purposeful change and initiate a larger and more enduring conversation about how interactions with safety net services can become empowering and affirming, rather than stigmatizing.

Limitations and future directions.

Despite its strengths, the current study also has several limitations. First, all contact with participants was remote due to COVID-19 and social distancing guidelines; while this may have protected the identities of participants in some ways, it limited data collection in others. Primarily, reliance on phone interviews removed some elements of the usual interview process, such as physical presence, a meeting space, and ability to see body language. It is unclear to what degree this may have affected information sharing and communication during interviews. Additionally, some audio and connection difficulties arising from phone interviews compromised the quality of some audio recordings, occasionally obscuring participants' words. Moreover, the current sample was limited to female-identified individuals only and thus the perspectives emphasized in this research may not be shared by people who identify with other

genders. It is also important to keep in mind that the perceptions and experiences of stigma discussed in this study may or may not be similar to that of women utilizing food banks and pantries in other cities and states in the U.S., as all women in this study lived in the Charlotte metropolitan area. Even within Charlotte, there seems to be some variability in the operations and procedures of these organizations (i.e., referral requirements, utilization limits), so application of the current findings to food safety net contexts in other locations should be considered carefully. Finally, member checks were not completed for a significant proportion of participants (24%); inability to complete member checks predominantly related to disconnection of phone service (three participants), while one participant did not respond to voicemails. This may reflect the fact that participants, given competing economic needs, may experience difficulties paying phone bills to keep their phones in service, leading to disconnection of the line.

There are many avenues for future research seeking to build upon the findings of this study. Because food banks and pantries only represent one of many safety net services available to individuals living in poverty, the degree to which the perceptions and experiences of stigma in this context generalize to other safety net environments (i.e., shelters, free clinics) should be explored further; this will allow greater understanding of which stigma-related factors and processes are unique to particular contexts, while others may be shared across contexts. Moreover, the current sample consisted of women exclusively, and findings suggest that elements of stigma perceptions may be informed by gender roles and socialization (e.g., providing for family; Ivers & Cullen, 2011); research is still needed to elucidate the degree to which the gender identities of male-identifying, transgender, and gender nonconforming individuals may influence the experience of poverty-related stigma. Furthermore, women frequently referred to their children when speaking about household food insecurity; perspectives

from youth experiencing food insecurity may lend insight into intra-household differences in food security status and how awareness of stigma may evolve throughout development. Utilization of focus groups (Morgan, 1997) may also bring greater depth of understanding of how stigma is conveyed and perceived by individuals within the food bank/pantry environment, as dynamic discussion may clarify shared and diverging stigma experiences. Future research may also seek to explore how environmental cues may contribute to perceptions of stigma both within and outside of the food bank/pantry context, to better elucidate how stigma-related symbols take on meaning over time. Another promising avenue for future endeavors in this area may emphasize the staff of food banks and pantries and their level of stigma awareness and endorsement of stigmatizing messages; not only would this offer fruitful information about stigma processes and communication of stigma during social interaction, but also may lead to conversations between food bank/pantry staff and recipients regarding how to mutually improve this service. Finally, empirical knowledge of stigma relating to poverty may be furthered significantly by the development of a measurement of perceived poverty-related stigma. Such an instrument would allow poverty-related stigma to be measured in a standardized way, allowing for comparison and contrast across populations, contexts, and time.

In conclusion, the present study expands upon known associations between stigma and health, offering a conceptual framework by which this relationship may be better understood among individuals who experience poverty and food insecurity. Importantly, this research emphasized the lived experiences of women who used food banks and pantries to meet their food needs, providing more constructivist, nuanced recognition of how stigma is perceived, managed, and situated within broader interpersonal and structural contexts. By using an intrapersonal lens to understand participants' narratives, this research not only contributes to the larger interdisciplinary stigma literature by clarifying the essential psychological processes that unfold

in response to stigma, but also highlights the importance of including the perspectives and expertise of those who experience it.

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APPENDIX A

Interview guide.

Introduction

Hi _____, my name is Rachel and I am a graduate student in the Clinical Health Psychology program at UNC Charlotte. I'm doing some research with people in the Charlotte area who experience issues with affording and getting enough food to meet their needs. I'd like to ask you some questions about your perspectives and experiences so that I can better understand food insecurity in our community. My goal here is to get a detailed understanding of how food banks and food pantries in the Charlotte area are meeting the needs of people like you. Eventually, I would really like to use what you tell me to improve the quality of these services by informing food banks and food pantries of how they can do a better job of serving the community. Does that sound okay with you? (address any questions or concerns).

Before I start recording, I want to use a pseudonym (a false name) to refer to you throughout the interview in order to protect your identity. What name would you like me to use?

Question	**Prompt(s)**
Tell me a little bit about yourself. (Demographics: age, race, gender)	What is your living situation like? If you work, what is your job like? Who do you typically interact with in your day-to-day life?
What does the term "food insecurity" mean to you? *Not having enough food to get through the month and not being able to afford more as an alternate descriptor*	How did you come up with that definition?

Does not having enough food ever influence your health? Does not having enough food ever influence how you feel?	How about your mental health? (for those who only give information about physical health)
Tell me about your experience of not having enough food in the Charlotte area.	How do you access food? What resources do you use when you do not have enough food? How does accessing and buying food affect your ability to meet your other needs or get other resources? *Do you ever share or barter food with others to make ends meet?
For these next few questions, I'd like to learn more about your experience using food banks and pantries that are not related to the Hearts and Hands Food Pantry. When you answer, please exclude your thoughts and experiences about the Hearts and Hands Food Pantry, and focus on your visits to other food banks and pantries in the community. Does that sound okay? Tell me about your experience using food banks and pantries in the Charlotte area.	Walk me through the steps you had to take to receive services from the food bank/pantry. What was it like to go through that process? What was it like shopping at the food bank/pantry? How does using the food bank/pantry meet your food needs? What food needs are still unmet?

How has the recent coronavirus pandemic affected your ability to get food?	
Was there a time that you were unsatisfied with the services that the food bank/pantry provided?	How satisfied are you with the amount of food that you receive from the food bank/pantry? How satisfied are you with the quality of the food that you receive from the food bank/pantry?
How are you treated when you visit the food bank/pantry?	What was it like interacting with the people who worked at the food bank/pantry?
Was there a time that you felt ashamed or embarrassed when visiting the food bank/pantry? Was there a time that you felt angry or frustrated when visiting the food bank/pantry? What other emotions came up for you when you visited the food bank/pantry? What sorts of thoughts went through your mind when you visited the food bank/pantry?	How did this experience affect the way that you feel about yourself? How did this experience affect the way that you feel about your situation? How did this experience affect your desire to visit that food bank/pantry again?

How did you learn about the Hearts and Hands Food Pantry?	What are some of the benefits of using the Hearts and Hands Food Pantry? How is the Hearts and Hands Food Pantry different from other food pantries you have used in Charlotte?
How do you think food pantries in Charlotte could be improved or changed to be more accessible to you?	If you could change one thing about how food pantries in Charlotte operate, what would it be?
What sorts of services or resources could the community provide that might be helpful to you?	What specific factors would make it easier to meet your food needs?

Wrapping Up

Those are all the questions that I have for you right now. Is there anything else that you would like to share with me that you think is important for me to know? Do you have any questions for me?

So, I'd like to tell you about what I plan to do with the information that you've shared with me today. Our interview will be part of a larger research project that explores the ways that people experience food insecurity in the Charlotte community. I think that it is important to get a sense of how people deal with food insecurity and hunger in an urban area by using services like local food banks and pantries. and how stigma might be related to this experience. Specifically, I want to investigate how things like stigma, shame, and embarrassment may influence people's decisions to use community food banks that offer food resources. For my research, I will be analyzing our conversations, as well as similar conversations with other people who visit Hearts & Hands Food Pantry, to find common themes and important issues that come up across interviews. My hope is that the information you shared with me today will be used to improve

food bank and food pantry services to better meet the needs of the Charlotte community, based on your valuable perspective.

One thing that can be really helpful is to check back in with you to make sure that I have an accurate understanding of what you told me today. This would involve me sending a summary of what we talked about to your text messages or email, then we would talk over the phone about whether or not I have correctly interpreted what you mean. Does this sound like something you would be willing and able to do?

I really appreciate you sharing your story with me and being so open and willing to talk—I think that your experience will bring some really important perspectives to this topic. Are there any other questions or concerns that you have at this time?