INTERSECTIONS OR ROOTS:

UNDERSTANDING ANTI-FAT BIAS THROUGH THE LENS OF ANTI-BLACK RACISM AND THE APPLICABILITY TO COUNSELLING PRACTICE

by

Alexandra Shewan

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APPROVED BY

André Serzisko, MA, RCC, Capstone Supervisor, Program Director MC Vancouver Island

Lisa Gunderson, Ph.D., Capstone Supervisor, Course Consultant

School of Health & Social Science

Abstract

Anti-fat bias is pervasive on a global scale, yet rarely acknowledged as an important intersection of identity that is systemically discriminated against. Moreover, the foundation of anti-Black racism that upholds anti-fat bias is rarely contextualized. Systems founded in white supremacy maintain the separation of these biases so that each is individualized and pathologized to place the locus of control of oppression on those experiencing discrimination instead of the systems that create oppression, thus perpetuating these systems. This cyclical pattern of anti-fat bias is repeated in systems of medicine and mental health, which are intended to promote the health and well-being of all, fat people included. Those in positions of helping are subject to the same societal messaging of anti-fat bias and anti-Black racism. However, counsellors are offered a distinct opportunity to disrupt both anti-fat bias and anti-Black racism personally, professionally, and systemically to decrease the suffering of their clients and communities.

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Dedication

This work is dedicated to anyone who has ever experienced body-based oppression, whether it be due to your body size, race, gender, ability, sexuality, or any of the intersections between all of the magnificent identities you possess. Your body is not and never was the problem. We deserve better.

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Land Acknowledgement

This paper was written on the lands of the Lekwungen peoples, the Esquimalt and Songhees nations, and the W̱SÁNEĆ peoples, the Pauquachin, Tsartlip, Tsawout, Tseycum, and Malahat nations, whose traditional relationship to the land continues to this day.

As part of this land acknowledgment, I would like to add some personal reflections. My name is Alexandra Kelsey Shewan, and I was born on the lands of the Kwantlen people, colonially known as Langley, British Columbia. I am the granddaughter of Jill Alexander, who was born on the lands of the Lekwungen peoples, and Doris Pound, born on the lands of the Mi'kmaq. I am not an uninvited guest, or a settler on these lands. My ancestors were both trespassers and colonizers. From their lineage, I am a trespasser who participates in and benefits from the colonial occupation we call Canada, which was founded on and is maintained by enacting violence against Indigenous lands, bodies, and relations.

While I have intersecting identities that contribute to my own experiences of oppression and privilege, I am, above all else, white. My whiteness, and the whiteness of my ancestors, has given me the privilege that white supremacist, colonial society provides. Not only can I choose to access the privilege of my whiteness at any time, but it is the baseline from which I navigate the world as I live and work as a trespasser on unceded Indigenous lands. I would also like to acknowledge one of the more insidious forms of colonization as it pertains to counselling and mental wellness workers: the colonization of the mind. With the proliferation of the DSM and white, European conceptualizations of mental distress, Indigenous ways of expressing mental

distress are being globally eradicated (Watters, 2009). By ignoring the fact that mental distress is bound by both culture and time, not only are culturally informed expressions of mental and spiritual distress being lost, but also culturally informed ways of healing (Watters, 2009). The pathological model of the DSM de-contextualizes people from their cultures and place in history, claiming false universal truths based in white supremacist systems. This de-contextualization frequently conceals and mitigates violence, thus locating social acts within the mind of an individual.

In acknowledging these lands, I acknowledge the violence of colonialism that I, and my ancestors, enact. In acknowledging this violence, I acknowledge the parallel history and ongoing presence of Indigenous resistance. I would like to express my gratitude to the Lekwungen and W̱SÁNEĆ peoples, as I stumble and learn, while recognizing my non-consensual presence on these lands.

Self-Positioning Statement

In alignment with Reynolds' (2019) call for mental wellness workers to promote justice in their work while navigating their own intersections (Crenshaw, 1989) of privilege and oppression, it is necessary for me to further locate myself within this work. I am a white, mid-fat, chronically ill, able bodied, economically privileged, English speaking, Canadian citizen, cisgender woman of European descent. My intersecting identities offer me the briefest exposure to experiencing oppressive systems, primarily my intersection of being both fat and a woman. However, my whiteness and other privileged identities shield me from the majority of harms perpetrated by oppressive systems. This can be illustrated through an experience I had while writing this capstone.

I experience chronic back and neck pain, and my family doctor sent me for an MRI. My first question to him was, "Will I fit in the machine?" – knowing that fat people are routinely humiliated and denied care because medical systems are founded on pathologizing fatness and, thus, have very few accommodations for fat people. My doctor assured me that there are two sizes of machines, and the hospital would book me accordingly with the information on my chart. I arrived in the MRI department of my local hospital and was shown the changing area by a thin technician. She scanned by body up and down and selected a gown and pants for me to change into, showing me where the larger tops were, if needed. She also gave me a form to complete and pointed out that I would need to fill in my current weight. I informed her that I do not know my current weight and that my doctor said all of my information could be taken from my chart. She left and I changed into the scrubs she selected for me, which were tight and uncomfortable across my hips and stomach. These were my first reminders that these systems

are not made for people with bodies like mine. Next, I found a place in the waiting room to complete my form. All of the chairs were narrow and had arms. There was only one wider, accessible chair, which was occupied by a thin person who had their multiple bags and jackets comfortably next to them on the seat. I found another seat and the pressure of the chair arms on my thighs and hips were another reminder that these systems are not made for people with bodies like mine. I began completing the form and left the “current weight” section empty. A different thin technician came to collect my form and noted the absent number, and I informed them that I had already shared with the other technician that I do not weigh myself, my doctor said the measurement could be taken from my chart, and that I do not want to know what that number is. The technician seemed confused but did not challenge me and recorded the number from my chart. They left and came back, informing me that they needed a same-day measurement to ensure accuracy. I was confused as to why they would need such an accurate weight measurement for an MRI yet obliged as the technician allowed me to face away from the scale and quickly cleared the numbers when they were done. As I put my shoes back on, they apologetically let me know I would be taking them off again momentarily. I joked that this was good practice, using my well-rehearsed comedic skills to keep the favour of the technicians, knowing that my body size alone already put me at much higher risk of being considered a non-compliant patient.

I was then shown to the imaging room by two thin technicians who helped me get comfortable on the machine. The conveyor began to move me into the tunnel and then stopped at my upper arms. I was in there for a few moments, feeling the pressure on my sides, wondering if the machine broke, or perhaps I only had to go in this far for an image of my neck

and shoulders, or maybe they would remove the pads so I could fit more comfortably. As the two thin technicians brought me back out, they told me that I would not fit in this machine, the larger one was not available, and I would have to come back another time. The heat of humiliation rose quickly in my face and I left the hospital as quickly as I could, head lowered to hide the tears quickly welling up in my eyes and sobs desperate to heave from my chest. I was thankful that I was wearing glasses and a face mask on to hide my embarassment as I got out of the hospital as quickly as possible, head hung low. In recounting this story, I note that all of the technicians I encountered were thin because this added to the othering of this experience. Though anti-fat bias would have been present regardless of the body size of the technicians, the presence of another large body would have created more safety and potential for solidarity. I also note their body size because anti-fat bias could lead the reader to assume thinness whether or not I comment on the body sizes of the technicians.

While this was one of the most humiliating experiences I have had, my life was not in danger. The same cannot be said for Ellen Maud Bennett, a 64-year-old Victoria woman who died in 2018 within weeks of her cancer diagnosis after years of feeling unwell and seeking medical intervention (Times Colonist, 2018). Ellen used her obituary to call out the anti-fat bias that led to her death, saying;

> A final message Ellen wanted to share was about the fat shaming she endured from the medical profession. Over the past few years of feeling unwell she sought out medical intervention and no one offered any support or suggestions beyond weight loss. (para. 1)

Ellen's story is tragic, yet common when contextualizing it within the experiences of most fat people who seek health care (Gordon, 2020), showing how the lethal lack of care she experienced is indicative of a serious, systemic problem affecting fat people.

Although during my MRI, or lack-there-of, the technicians were not overtly discriminatory, the process of navigating these medical systems was discriminatory and unsafe for me because of anti-fat bias. I do not know whether or not any of the technicians or medical professionals involved in my care hold overt anti-fat bias, yet negative intentions are not necessary for there to be discriminatory consequences (Staats, 2014, p. 72). It took the booking department a month to rebook my appointment after what my doctor described as an unnecessary amount of back and forth trying to explain why I need the larger machine. From the time I was denied care due to anti-fat bias, to the date of my forthcoming MRI, six months will have passed. Six months that I am left wondering about my health. Six months that a thin person would not have to wait. After months of self-advocacy and speaking to a more senior medical professional each time, I was moved up on the list and have received my MRI 3 months after my initial appointment. How many other fat people do not have the capacity to do the same, or did not receive as positive of a response, and are denied medical care?

This is inconsequential compared to the medical care that fat people are routinely denied, often left in pain with injuries that could be healed with surgery. Medical practices being built around thin bodies means anesthesia is riskier for fat people, which is what fat people often hear when being denied important surgical care. And yet, many fat people can speak to their experience of doctors being willing to risk anesthesia for bariatric surgery. It is

considered normal and sound medical practice to recommend the amputation of a fat person's fully functioning organ so that they can navigate an increasingly anti-fat world.

It is common for those involved in body positive or fat positive activism to claim that anti-fat bias is the last remaining form of discrimination that is socially acceptable. I have proclaimed this idea in past work. However, I now know that this line of thinking inherently centers whiteness. As anonymous essayist Your Fat Friend (2017) says,

> "the last acceptable form of discrimination" implies that you have reached the end of your learning. It tells me that your life is uncontested enough to let you believe that one day, oppression just ends. You do not know or remember the ways in which it is forced beneath the surface, the way it mutates in the swampy waters of our subconscious. You have not seen its monstrous face lurking in the depths below. You have not felt the tug of its undertow on your ankle, threatening to pull you under… You do not know that I do not fear for my life as a fat person. Fat hate may drive some to mock me, hurt me, insult me, deny me services, health care or a job. But it likely will not drive someone to murder me. Each day, I wake up a fat woman in a world that wishes I didn't exist. But I also wake up a white woman in the United States. I wake up in a home of my own, with friends — like you — who love and support me. Yes, I am hurt. But I also carry generations' worth of gifts and benefits, bestowed by a culture that values my whiteness above all else (para. 28-31)

My intention in this paper is not to speak for those who have identities other than mine. Though examining anti-Black racism is central to this paper, I recognize that as a white woman

who participates in and benefits from racism, I can never speak for Black communities nor pretend to have a shared understanding of their experiences of oppression.

Chapter 1: Research Problem

Kinavey and Cool (2019) reiterate a point made by many social-justice-oriented therapists, that “the work of therapy is not to help people adjust to oppression" (p. 123). This paper will outline how anti-fat bias is actively encouraged, both broadly within society and specifically in the field of psychotherapy. The connection between anti-Black racism and anti-fat bias will be examined, and its acknowledgement by researchers and professionals assessed. This analysis will pay special attention to how and when whiteness is centered in the literature, research, and practice. Recommendations will be made, building on Kinavey and Cool’s (2019) list of “ten ways to shift your therapeutic lens” (p. 121), and Reynold’s (2019) philosophical framework of justice-doing at the intersections of power. Guided reflection questions will be included to support mental health service providers to examine their own relationships to food, exercise, health, their bodies, and white supremacy, and how these attitudes show up explicitly and implicitly in their work with clients. To work more ethically and truly support the mental wellness of clients, both anti-fat bias and anti-Black racism must be acknowledged for the systemic issues they are, not erased nor treated as individual problems.

Bodies have always existed in a plethora of forms. As humans evolved, so did height, weight, ability, skin colour, and other features, through interaction with environments (Birx, 2006). However, this does not prevent modern anti-fat bias from imposing current perspectives on the interpretation of bodies throughout history. As far back as 25,000 years ago the fat body of the Venus of Willendorf was noteworthy enough to idealize in limestone (Willermet, 2006). Anti-fat bias defines thinness as the natural state of humans, though fat people have always lived full, healthy lives, and have historically been celebrated and highly desired. An

understanding of the trend towards a *pro-thin ideal*, the idea that thin bodies are inherently more valuable, over the past 400 years has eluded white Western conceptualizations of bodies. Instead, the historical context was replaced with biased research that perpetuates the myth that fatness is inherently immoral and unhealthy. Modern Eurocentric culture is so steeped in anti-fat bias and pro-thin ideals that even history is viewed through a lens of compulsory thinness (Gordon, 2020; Strings, 2019).

Fortunately, the context and history of the pro-thin ideal and anti-fat bias have become clearer in recent years, as Dr. Sabrina Strings (2019) provides the missing link between modern demonization of fatness and its historical context in her book *Fearing the Black Body: The Racial Origins of Fat Phobia*. She paints a deeply contextual picture, connecting the rise of pro-thin ideals and anti-fat bias to slavery, colonization, white supremacy, and the influence of Protestant morality on white cultural norms. She highlights how race scientists of the enlightenment era drew a link between Blackness and fatness to dehumanize Black people and justify the enslavement of African peoples. This created a pro-thin ideal that white women could use to distance themselves from Blackness and represent their Protestant morals through the size of their bodies and dieting behaviours. While the term *pro-thin ideal* is the most accurate way to describe how thinness and fatness are placed at opposite ends of a spectrum that also measures morality and whiteness, it is important to note that the conceptualization of thinness has ebbed and flowed throughout time. For example, Strings (2019) introduces her book with an article from the New York Times published on February 16th, 1894 in which the journalist reports that the current white culture trend towards slenderness is a threat to the nation. Though doctors of that time were concerned with this pro-thin ideal, by this point in

history the pro-thin ideal was already firmly tied to good morals and whiteness in Western culture.

The pro-thin ideal has changed over time, particularly in the 20th century, as embodied by popular culture figures such as Marilyn Monroe (Marilyn Monroe Collection, 2019), and Kate Moss during the *heroin chic* era of the 1990s (Cole & Deihl, 2015), and yet these ideals have consistently remained within a range of thinness that is still acceptable and desirable. It is frequently said that Marilyn Monroe wore a size 12-16, which misconstrues how accepting 1950s cultural ideals were of larger bodies. Clothing patterning has significantly changed over time and Marilyn's body size was equivalent to a modern-day dress size six or eight (Marilyn Monroe Collection, 2019), still well within a pro-thin ideal in the 1950s and now.

The line of body size acceptability and pro-thin ideal differs in Black communities; being thick is seen as a standard of beauty in many Black communities (Cassidy et al., 2018). While many Black communities are more accepting of diverse body sizes, the line of body size acceptability still exists where people are no longer seen as the positive thick but as the negative fat (Cassidy et al., 2018). This demonstrates the importance of decentering whiteness when defining the pro-thin ideal and understanding that this ideal will range depending on cultural perspectives.

The term pro-thin ideal is often used interchangeably with the term *beauty standards* or *Euro-centric beauty standards*. However, this terminology is not specific enough for the purposes of this paper because the term beauty standards hides the anti-fat bias that exists in its foundation. Pro-thin ideal will be used to continually evoke anti-fat bias and how this binary

way of thinking diametrically opposes thin/moral/good/white and fat/immoral/bad/Black. This demonization of Black bodies and demand for thin, compliant, white bodies has been politically, economically, and socially expedient for white Europeans since colonization and the slave trade (Strings, 2019). In the last 400 years, as Black activists have made significant gains, white supremacy has shape-shifted to continue the demonization and oppression of Black bodies through systemic racism, including anti-fat bias and the *obesity epidemic*.

Anti-fat bias is rampant and leaves very few people on the planet untouched by its insidious grasp (Bacon, 2020; Bacon & Aphramor, 2014; Gordon, 2020; Harrison, 2019; Taylor, 2018). This paper will speak specifically to the cultures of Canada and the United States where the effects of colonization and white supremacy are woven into the fabric of everyday life (DiAngelo, 2018; Strings, 2019; Warbrick et al., 2018). The connection of anti-fat bias and anti-Black racism is often erased, as people of all racial identities and sizes are impacted by anti-fat bias. The societies and systems of Canada and the United States are built to center white experiences (DiAngelo, 2018; Strings, 2019), so white people are often centered when speaking to the harms of anti-fat bias. A recent mainstream adoption of body positivity, created by and for fat people (Gordon, 2020), is being overwhelmed by thin white women centering their own negative experiences with Eurocentric beauty standards and the pro-thin ideal instead of focussing on those with marginalized identities who shoulder the systemic burdens of anti-fat bias and anti-Black racism (Bacon, 2020; Gordon, 2020; Harrison, 2019; Johnson, 2019). Fat activists are fighting against multiple layers of diffusion of their own liberation, being marginalized within their own movement due to watering down fat liberationist ideas in order to gain mainstream support in a white supremacist society.

While anti-Black racism continues to be widespread, overt, and systemic, this discrimination is now also couched in the language and systems of helping those who are marginalized by these same systems. It is well documented that what researchers claim are the negative effects of *obesity* disproportionally impact Black, Latinx, and Indigenous communities (Bacon, 2020; Cassidy et al., 2018; Johnson, 2012; Milburn et al., 2019; Nutter et al., 2018b; Warbrick et al., 2018). For example, researchers and medical professionals alike attribute high rates of diabetes in Black communities to *obesity* (Bacon, 2020). Anti-fat bias' false connection of ill-health and fatness has been so firmly rooted in societal and medical systems that this has become a common-sense claim, resulting in fat people being told that all of their ill-health is due to their fatness (Bacon & Aphramor, 2014; Gordon, 2020; Harrison, 2019). There are numerous stories about fat people seeking medical attention for something completely unrelated to their weight and still being recommended weight loss (Bacon & Aphramor, 2014; Gordon, 2020; Times Colonist, 2018). Not only are fat people given inadequate medical care, but people who are not fat are given sub-par medical care because medical professionals assume that a small body indicates overall good health. Anti-fat bias causes people in smaller bodies to be neglected and not have important aspects of their health examined because of these assumptions (L. Gunderson, personal communication, March 12, 2021). The stress of experiencing consistent interpersonal and systemic marginalization is rarely considered when researching and treating diseases like diabetes that disproportionately affect those who are both fat and Black (Bacon, 2020). Instead of changing the conditions that produce ill-health in communities, like systemic racism and anti-fat bias, the locus of control of health is placed

within individuals (Elison & Çiftçi, 2015) and addressed through helping individuals to make better choices about their eating and exercise behaviours.

These individualized interventions, frequently in racialized communities, have been justified through the declaration of the *obesity epidemic*, which proliferated widespread moral panic through media outlets reporting on biased and bad-faith medical research about body size (Campos et al., 2006; Nutter et al., 2018b; Puhl & Heuer, 2009). The most acute example of this bad-faith, anti-fat biased medical practice was in 1998 when the qualifiers for BMI categories were arbitrarily lowered, making thousands of people *overweight* or *obese* overnight (Bacon, 2008; Gordon, 2020). This single policy change has had significant and lasting effects, as Gordon (2020) points out that "even today, the bulk of the data on the so-called obesity epidemic fails to account for this change in standard, showing a sharp spike in fatness in 1998, as if everyone in the US suddenly gained dozens of pounds" (p.51). This change, along with minor increases in BMI numbers to move people just over the thresholds from *normal* to *overweight*, and *overweight* to *obese* are what get reported on as an epidemic (Campos et al., 2006). The changes in population weights are very small, yet the crude inaccuracy of the BMI gets further distorted by unethical reporting that perpetuates the idea that humans are dangerously fatter than ever before (Gordon, 2020).

The misuse and medical dependence on the BMI as a measurement of health continues to conveniently frame *obesity* as a personal issue, one that places the responsibility of a community's overall health on each of its members instead of the discriminatory systems those members must navigate. *Obesity* is used as a scapegoat for all ill-health and, thus, the responsibility is placed on individuals to change their behaviours to reduce *obesity* instead of

holding institutions accountable for their discriminatory and predatory systems that cause the overall, including mental, physical, and spiritual, ill-health of marginalized communities (Bacon, 2020; Becker et al., 2017; Harrison, 2019; Gordon, 2020; Kinavey & Cool, 2019; Lucas et al., 2016; Smith, 2008; Warbrick et al., 2018).

Common diseases or health concerns attributed to fatness are high blood pressure, poor nutrition and exercise habits, diabetes, and cancer (Bacon, 2008; Tomiyama & Mann, 2013). Studies on the negative effects of *obesity* rarely control for systemic factors like racism, anti-fat bias, or how the two intersect, nor the effects of those systemic inequalities like:

- higher allostatic loads and experiences of chronic stress,
- reduced access to medical care,
- harmful treatment when accessing medical care,
- poverty,
- food insecurity, and
- food deserts (Bacon, 2020; Gordon, 2020; Smith, 2008).

This culminates in a victim-blaming attitude towards those who are fat, as they are held responsible for their fatness as well as the impacts of navigating an intersectionally oppressive society (Kinavey & Cool, 2019; Smith, 2008; van Amsterdam, 2013).

A Note on Language

Throughout this paper, medicalized definitions of body size, such as *obesity*, *overweight*, *normal weight*, and *underweight* will be italicized to denote the subjectivity of these terms. Modern conceptualizations of bodies are rooted in biased medicalization which needlessly

pathologizes body size and defines overall health solely by body size (Bacon, 2008; Bacon & Aphramor, 2014; Elison & Çiftçi, 2015; Harrison, 2019; Nutter et al., 2016). These terms have proliferated through the creation of the Body Mass Index (BMI), a weight/height mathematical equation intended to measure general population statistics, whose inventor stated upon its creation in 1832 that it was not meant for individual diagnosis or medical use (Gordon, 2020; Harrison, 2019; Strings, 2019). The genesis of the BMI is rooted in the race science of the enlightenment era (Gordon, 2020; Strings, 2019), and was "developed… using an exclusively white, European population" (Harrison, 2019, p. 35). For these reasons BMI categorizations of body size are arbitrary, biased, and limited, and will be referenced as such throughout this paper.

Though still a stigmatized term in mainstream use, the word fat will be used to describe larger bodies, instead of *obesity*. This is in alignment with fat activist's reclamation of the word as a neutral descriptor, such as tall or short, instead of the pejorative way fatphobic culture demands (Gordon, 2020; Harrison, 2019). Many fat activists now regard the terms *overweight* and *obesity* as slurs, highlighting the ways in which this word is used to systematically dehumanize and oppress fat people. *Obesity* is frequently censored in fat activism spaces, written instead as *o*sity* or, in some cases, censored entirely (Harrison, 2019).

The term white supremacy will be used to reference how social, political, and cultural systems are crafted with the express purpose of centering whiteness and perpetuating anti-Black racism (Bacon, 2020; DiAngelo, 2018; Jaynes, 2005; Strings, 2019). This term is not used to evoke images of white power groups or individuals who act on their bigoted beliefs, but to acknowledge how the colonial foundations of society in Canada and the United States are

dependent on the dehumanization and oppression of Black, Indigenous, and racialized people to uphold whiteness (DiAngelo, 2018; Hunt, 2016; Strings, 2019). In this vein, the term white will never be capitalized in this paper, as the capitalization is associated with white power groups (Coleman, 2020). Conversely, the term Black will always be capitalized when referencing Black communities to respect the term as a cultural identity, not just a colour (Bacon, 2020; Coleman, 2020). When referencing Black communities, the word communities will always be pluralized. This is to acknowledge that the experiences of all Black peoples are not monolithic.

Just Say Fat

Anti-fat bias knows many names: fatphobia, fat-antagonism, weight bias, weight stigma, pro-thin ideal, and healthism, to name a few. Throughout this paper, the term anti-fat bias is used to describe the type of bias that marginalizes fat people, unless other terminology is used by a specific study or author. Though fatphobia is a commonly used term in fat liberation communities, it perpetuates individualistic thinking, locating the problem within thoughts or feelings of a single person. This is likened to Ibram X. Kendi's (2019) use of the term antiracist. As he says,

> The opposite of racist isn't 'not racist.' It is 'antiracist.' What's the difference? One endorses either the idea of racial hierarchy as a racist, or racial equality as an antiracist. One either believes problems are rooted in groups of people, as a racist, or locates the roots of problems in power and policies, as an antiracist. One either allows racial inequities to persevere, as a racist, or confronts racial inequities, as an antiracist. There is no in-between safe space of 'not racist.' (p. 9)

Though there is nuance to the variety of terms under the umbrella of anti-fat bias, each of these terms are dependent on the existence of systemic anti-fat bias. The pro-thin ideal was created as a counterpoint to the dehumanization of fat, Black bodies (Strings, 2019), weight cannot be stigmatized unless there are definitions of normalcy that locate fatness as abhorrent, and healthism is predicated on the false claims that all fat bodies are unhealthy, all thin bodies are healthy, and physical health must be pursued at all times and at all costs.

Anti-Fat Bias, Anti-Black Racism, and Academia

Academia often amplifies bias because it is a Eurocentric institution that centers whiteness and those with privilege (Heine, 2012; Mentan, 2015). Thus, academic literature has not only ignored the existence of anti-fat bias, but it is also responsible for a large part of the proliferation of anti-fat bias under the guise of common-sense health claims (Aphramor, 2017; Bacon, 2008; Bacon & Aphramor, 2014; Elison & Çiftçi, 2015; Kinavey & Cool, 2019). Though the faculty of medicine has long been mostly to blame for perpetuating anti-fat bias (Alberga et al., 2019; Aphramor, 2017; Bacon, 2008; Bacon & Aphramor, 2014; Gordon, 2020; Harrison, 2019), the social sciences are not immune (Kinavey & Cool, 2019; Young & Powell, 1985). The majority of research on body size, often *obesity* research, rarely includes anti-fat bias as a mitigating variable (Puhl & Heuer, 2009). Instead, researchers take a healthism perspective, automatically positioning *obesity* and *normal weight* at opposite ends of a spectrum of health. Correlational studies draw false causal results between *obesity* and various diseases, failing to acknowledge that, even if there were a causal relationship between variables, the direction of the relationship may not always be one way with *obesity* causing disease. The possibility that fatness could be a symptom of many diseases is rarely considered (Bacon, 2020). The omission

of anti-fat bias from studies on the negative effects of *obesity* also erases the fact that experiences of discrimination and oppression significantly add to a person's allostatic load, which produces ill-health (Bacon, 2020; Smith, 2008). Additionally, *obesity* studies frequently place the locus of control for *obesity* within individuals instead of environment and genetics, which are much more powerful determinants of body size than dieting and exercise behaviours (Bacon, 2020; Gordon, 2020; Harrison, 2019). Nutter et al. (2016) succinctly point out this fault in methodology, that "the success of behaviour modification obesity interventions is often measured through how much weight a person loses; however, weight is not a behaviour" (p. 3).

There is a high probability that further evidence for the above claims will be found in the literature review of this paper. The few studies that do acknowledge anti-fat bias will not include anti-Black racism nor make the connection between the two forms of discrimination. Studies that measure anti-fat bias, body dissatisfaction, and internalized weight stigma will likely use measurements that center whiteness, erasing how anti-fat bias shows up differently in Black communities. An overwhelming emphasis on health and conflation of thinness and health and fatness and ill-health will probably be found. These definitions of health will center whiteness and Western individualism which ignores systemic and holistic aspects of health and wellness. It could also appear that overt anti-fat bias has decreased and, instead, now shows up primarily through healthism, which reflects the increasing societal awareness of the negative effects of diet culture but couching the same anti-fat attitudes in an attitude of promoting health (Elison & Çiftçi, 2015; Harrison, 2019). This will culminate in a body of evidence that continues to center whiteness and stigmatize both fatness and Blackness.

Anti-Fat Bias, Anti-Black Racism, and Counselling

Since Young and Powell's (1985) seminal study, counsellors have known that mental health professionals exhibit anti-fat bias, and yet little has been done to mitigate the influence of this bias in psychology (Kinavey & Cool, 2019; Nutter et al., 2018b). Smith (2008) clearly articulates that counselling psychologists have long been at the forefront of addressing social justice in the field of psychology. However, as recently as 2012 the then-president of the American Psychological Association (APA), Dr. Suzanne Bennett Johnson, wrote a column calling for the APA and its members to address the *obesity epidemic*. Johnson (2012) cited many statistics around the rise of *obesity* in recent years and correlated issues such as higher mortality and various health complications. She claims that psychologists should prioritize supporting their clients in making behavioural changes to reduce their *obesity*, in alignment with the APA's obligation to promote the health of their clients. However, Nutter et al. (2016) identify that "by being complicit with this discourse of the obesity epidemic, researchers have asserted that large bodies will continue to be excluded, marginalized, and regarded as immoral" (p.4).

Johnson claims that "the obesity epidemic is not a product of changing genes or biology. It has its [sic] roots in the social environment and human behavior," which aligns with the faulty methodology most *obesity* studies adopt, positioning weight loss, which is not a behaviour, as a measurable result of behaviour modification (Nutter et al., 2016). Many of the statistics Johnson (2012) uses to emphasize the direness of the epidemic position Black women as most impacted by and vulnerable to *obesity*. There is no mention of anti-Black racism, or discrimination of any kind, and how the chronic stress of marginalization impacts health. A

consequence of Johnson's use of Black women's bodies is the perpetuation of discriminatory ideas about body size that will only cause more harm and ill-health to those the APA claims to be helping. This is the crux of anti-fat bias and anti-Black racism in psychology, psychotherapy, and counselling: well-intended professionals who are ignorant to anti-fat bias perpetuate anti-fat ideas under the guise of helping and cause serious harm to their clients by using strategies that further marginalize their clients rather than alleviate suffering.

Discrimination and microaggressions show up in many ways for fat people. Helping professionals engage in these damaging behaviours by:

- projecting their own body dissatisfaction on clients,
- assuming that the client's presenting problem must be due to their fatness,
- comparing their bodies to their client's bodies,
- telling clients to use their negative beliefs about their bodies to fuel motivation to lose weight,
- asking clients about their eating habits when they are speaking about the anti-fat bias they experience,
- assuming that fatness is protective and a product of trauma,
- forcing clients to look into a distorted mirror that makes them appear thinner,
- offering their own weight-loss tips, and
- ignoring fat clients when they speak about their body-based oppression (Bennett, n.d.).

These, and any other specific examples, are not intended to shame individual counsellors or other helping professionals, but to highlight the ways in which systems fail counsellors and

harm clients. Training programs for counsellors rarely address anti-fat bias, so student counsellors remain unaware that this is a possible bias they hold (Nutter et al., 2018b). Instead, education programs and regulatory bodies of therapeutic professions perpetuate the anti-fat bias that oppresses fat people and most acutely harms fat, Black clients.

Chapter 2: Literature Review

The purpose of this literature review is to examine how academic literature discusses anti-fat bias and anti-Black racism, and how these two concepts are, if at all, connected. Literature on weight stigma, racial stigma, and research methodologies will be examined for how they include or exclude fat people, Black people, and the intersections of these identities. The ways in which research is conducted, including participant makeup and assessment tools, will be examined for bias from both researchers and participants. The history and application of the most influential research and body size diagnosis tool, the Body Mass Index, will be explored. The ethics of recommending weight loss for promotion of health will be assessed, along with the inherent politicization of fat bodies. Discussion of how fat bodies are politicized will intersect with Blackness by highlighting common responses to Black and fat victims of police brutality and how the idea of certain identities being *unvictimizable*, unable to be victimized by violence, is rooted in anti-Black racism and proliferated through anti-fat bias.

Though Black communities are centered in the racial identity focus of this inquiry, globally Indigenous perspectives, voices, and scholars will also be included. There is a growing body of fat liberationist, decolonial research from Māori scholars (Gillon, 2020; Gillon & Pausé, 2021; Warbrick et al., 2018) in Aotearoa New Zealand. Regretfully, the scope of this paper cannot describe this important work in detail, but parallels will be drawn from their work to applicability to Canada and the United States.

Academic journals will be examined and specific attention will be paid to activists and thought leaders on this topic, particularly books by Strings (2019), Taylor (2018), Gordon (2020), and Bacon (2008; 2020). Academic research will also include an examination of how

marginalization more broadly affects the chronic stress of individuals, communities, and populations at large. Parallels will be drawn from literature describing how poverty negatively influences health, and how individuals are blamed for the effects of their own oppression within systems of power.

The BMI and Other Research Tools

The vast majority of the research conducted on body size, whether it be about health risks, discrimination, or other areas of study, uses the Body Mass Index (BMI) as a measurement tool to categorize participants (Puhl & Heuer, 2009). This crude height-versus-weight calculation is unable to measure health, and yet forms the foundation of not only research but also diagnosis and pathologizing of body size. The BMI does not provide specific measures of body composition, like fat, muscle, or distribution of those tissues, nor is it able to measure exercise or nutrition habits. Yet study after study makes claims about higher BMI measurements, *obesity,* causing a greater number and severity of negative health outcomes (Cassidy et al., 2018; Puhl & Heuer, 2009; Sabik & Versey, 2016). Anti-fat bias creates confirmation bias, resulting in researchers making false causal claims about correlational studies that do not have more specific measurements of health or body composition (Cassidy et al., 2018; Sabik & Versey, 2016; Taylor et al., 2015). Researchers often make appeals to common sense and previous biased research to prove a causal relationship between *obesity* and disease, creating ample space for anti-fat bias to influence their research (Cassidy et al., 2018; Sabik & Versey, 2016).

As a tool, the BMI is inherently discriminatory, specifically towards fat, Black, assigned-female bodies, and any intersections between those identities (Strings, 2019). This tool was

taken from the Quetelet Index (QI), created in 1832 by Lambert Adolphe Jacques Quetelet (Gordon, 2020; Harrison, 2019; Strings, 2019), a Belgian statistician who was "in search for *l'homme moyen* – an idealized average man" (Gordon, 2020, p. 47). The QI was created with the sole purpose of measuring populations, not individuals. 140 years later food deprivation researcher Ancel Keys adopted Quetelet's Index to create the BMI, specifically to measure *obesity*, not just body size (Strings, 2019). This is a subtle yet important distinction to note about the creation of this tool. In current conceptualizations, the BMI is thought to assess body size, implying a neutral approach to all bodies, and categorizing them accordingly. However, it was created to measure *obesity*, not simply assess all body sizes, which creates potential for confirmation bias to focus disproportionately on fat bodies. Keys' abhorrence of fat bodies is well-documented (Gordon, 2020). Despite his research showing how devastating the effects of starvation are, his main concern for future generations was an overabundance of food (Strings, 2019). What gets left out of Keys' championing of the BMI, over a century after the QI was created, is the context within which Quetelet developed his equation. The QI used an exclusively white, European, and male population to generate its categorizations of bodies (Gordon, 2020; Harrison, 2019; Strings, 2019). This is in alignment with the so-called race science being researched and practiced at the time by other white, European men who sought scientific proof to enable their racist, misogynistic, patriarchal power structures (Strings, 2019). Despite these discriminatory and non-health related origins, the BMI has become foundational to the majority of research, pathology, and treatment of fat bodies (Puhl & Heuer, 2009).

While the BMI is potentially the most misused measurement pertaining to fat bodies, other tools are misused when counselling researchers attempt to gather data on body size as it

relates to common therapeutic topics like eating behaviours and self-image (Awad et al., 2015). Research has generally assumed that Black people, particularly women and girls, do not experience as much body dissatisfaction as people of other races due to larger bodies being more desirable in Black cultures (Bucchianeri et al., 2016). What these conclusions fail to acknowledge is how the tools built to measure self-image and self-esteem are biased towards body size, which is a white-centric conceptualization of self-image, and not other aspects of self-image that are more influential for Black women and girls like hair and skin (Awad et al., 2015; Gordon, 2010). Research shows that, when the measurement tools account for culturally relevant influences, Black women and girls experience just as much body-dissatisfaction as their white counterparts, including body size (Awad et al., 2015; Bucchianeri et al., 2016; Cassidy et al., 2018). This omission of racial disparity perpetuates the pathology of fat bodies. Not only is fatness construed as inherently the responsibility of the individual, but also any negativity one might feel towards their body is their responsibility as well. This line of thinking continues to locate the problem of both fatness and shame of fatness within the individual, which perpetuates anti-fat bias, which then perpetuates negative health outcomes (Puhl & Heuer, 2009); and the insidious cycle of anti-fat bias continues.

Researcher Bias

Since the majority of research around body size and health purports to make common-sense, objective claims, it is rare for researchers to self-locate their body size within the work (Arthur et al., 2017). This creates another layer of bias that can influence results, as the anti-fat bias of both participants and researchers goes unnoticed. This could be due to the fact that the majority of research on *obesity* is funded by those who have vested interests in maintaining the

false causal connection between *obesity* and disease/mortality, such as pharmaceutical companies and physicians who own bariatric clinics (Capos et al., 2006; Fat Besties, 2020). These researchers and physicians who are writing studies on *obesity*, more often than not, possess thin privilege (Nutter et al., 2018); therefore, fat people are not given a say in the work that represents them. Fat people are rarely represented as researchers, medical and mental health professionals, or policy makers in the systems that make so many paternalistic assumptions about them (Nutter et al., 2018b).

Black Representation

Gordon et al. (2010) noted that medical and mental health professionals are less likely to recognize eating disorder behaviours in racialized populations; another result of Black women and girls being left out of the literature around negative self-image. Mental health regulatory bodies, particularly the APA, reinforce their fight against the *obesity epidemic* by making misguided ethical pleas to practitioners to help clients lose weight in order to protect clients from the negative effects of *obesity*, citing Black women as most vulnerable (American Psychological Association, 2021; Johnson, 2012). Black communities are framed as needing help from white-centric regulatory bodies, citing white-centric, anti-fat, and anti-Black research as justification for these interventions (Cassidy et al., 2018). This results in fat, Black women and girls being simultaneously ignored and overemphasized in the literature. Researchers and counsellors are told to support those who are most marginalized by engaging in weight stigmatizing practices that perpetuate the ill-health attributed to *obesity*. Instead of alleviating suffering by changing the anti-fat and anti-Black systems that marginalize communities, regulatory bodies continue to problematize fatness and individualize the treatment of this

constructed problem. This shows how anti-fat bias and anti-Black racism can be entrenched within mental health systems, medicine, and research.

Participant Make-Up

Researcher bias is most insidious when selecting populations to study. The majority of research is done in Western countries at Universities where researchers rely on undergraduate students to make up their participant pools (Heine, 2012). This builds bias right into the foundation of academic research, as the majority of participants will be white and of a higher socioeconomic status (Heine, 2012; Puhl et al., 2020). Moreover, studies make claims about associations between body size and other variables without recruiting a diversity of body size in their studies (Taylor et al, 2015). This bias is exemplified in Taylor et al. (2015), who sought to examine the connections between mindful eating practices, eating disorder symptoms, self-compassion, and BMI. This study claims to find "that self-compassion is positively predictive of mindful eating and negatively predictive of BMI" (p. 236), implying that self-compassion can help to reduce body size. They then recommend that mental health professionals employ self-compassion as prevention and treatment of *overweight/obesity*.

When examining the participant makeup of this study another story emerges. This study had 150 participants and their average BMI was 23.02, comfortably within the *healthy/normal weight* classification. Racially, white people made up 74% of participants, 12% identified as Hispanic American, and the remaining 14% were amalgamated into "other." In addition, 85% of the participants were female. When assessing the participants, it is clear that this study predominately speaks to the experience of thin, white women, and, thus, any conclusions about working with fat or Black people cannot be inferred. The inverse of the researcher's

claims could also be made, that a low BMI is predictive of greater self-compassion. Flipping the perspective when interpreting these results leads to the question of why? Why are there higher rates of self-compassion for those who are *normal weight*? Why are whiteness and thinness not controlled for when studying body size? Why were experiences of racism and anti-fat bias not assessed in connection to self-image, body size, and self-compassion? Why are those with privilege consistently given the right to speak for everyone?

Weight Loss

Weight loss is the most recommended strategy to improve the health of those who are fat (Kinavey & Cool, 2019). It is often the first thing medical professionals treat, above all else, and mental health professionals adopt this perspective (American Psychological Association, 2021; Johnson, 2012). This can be likened to approaches when working with people who are morbidly thin – the client's weight is treated as the main issue before anything else can be addressed (L. Gunderson, personal communication, March 12, 2021). In terms of fatness, the parallel assumption is made, that the client's life is under threat due to their body size and the most ethical approach for mental health professionals is to address the threat to their life first (American Psychological Association, 2021; Johnson, 2012).

This assumption is based on the falsehood that fatness is unhealthy. *Obesity* is frequently attributed as the cause for hypertension, cancer, type 2 diabetes, and general increased mortality (Bacon, 2008, 2020; Bacon & Aphramor, 2014; Campos et al., 2006; Cassidy et al., 2018; Harrison, 2019). Helping professionals assign behavioural modification to clients, such as dieting and exercise, to treat their fatness, often without even assessing for existing diet and exercise behaviours or a history of disordered eating (Harrison, 2019). This was my

experience in 2015 when a routine check-up with my then-family doctor showed I was in excellent overall health. He scoffed at me not wanting to know my weight, but complied, then proceeded to try and prescribe me a weight loss medication and self-help group without making any assessment of my current eating and exercise behaviours. This doctor saw my fat body as deviant (Gillon, 2020; van Amsterdam, 2013), as something he was ethically obligated to change for my own good. This paternalistic attitude infers that he was making assumptions based on his implicit anti-fat bias, presuming that I was lazy, stupid, and in denial for not wanting to know my weight. Weight loss recommendations for those with fat bodies leaves out important research about how eating and exercise habits are much more predictive of health than body size (Bacon, 2008). Tomiyama and Mann (2013) highlight that those labelled *obese* who are active have better cardiovascular health than those who are *normal* weight and sedentary.

A safe and effective long term weight loss strategy has yet to be discovered (Campos et al., 2006; Harrison, 2019). Countless studies have shown that weight loss does not work in the long-term and that most who lose weight will regain what was lost and more within 2-5 years (Bacon, 2008; Bacon & Aphramor, 2014; Hall & Kahan, 2018; Harrison, 2019). From an evolutionary perspective it makes sense that bodies are built to defend against weight loss, to store energy-dense adipose tissue for times of food scarcity (Harrison, 2019). Yet, the $60 billion diet industry leverages systemic oppression and anti-fat bias to expertly craft an environment of scarcity and uncertainty (Gordon, 2020; Harrison, 2019). As the research stands, the only outcomes that dieting can accurately predict is weight gain and a risk for disordered relationships to food and exercise (Bacon, 2008; 2020; Bacon & Aphramor, 2014;

Gordon, 2020; Harrison, 2019). The relationship between weight and behaviour is complex and those who wish to promote the health of all bodies, especially fat and Black bodies, will need to resist measuring weight, which is not a behaviour, as a health outcome of behavioural adjustment (Campos et al., 2006; Nutter et al., 2016).

Political Bodies

With the rise of *obesity epidemic* rhetoric, anti-fat bias and attitudes have also been on the rise (Kinavey & Cool, 2019; Puhl & Heuer, 2009; Tomiyama & Mann, 2013). The reverberations are felt by people of all sizes, as the social currency of white supremacist anti-fat bias dictates that all bodies must constantly prove their essential worthiness through eating, exercise, and social behaviours that white supremacist power structures deem are morally good (Kinavey & Cool, 2019). Even someone who is fat can traffic in this social currency by engaging in these moralistic behaviours. This is what Taylor (2018) refers to as the "hierarchy of bodies" (p. 58) – that people are conditioned by an environment of body terrorism to be constantly evaluating themselves and others in order to feel a sense of worthiness. Taylor (2018) goes on to describe her concept of *body terrorism* as "the historical and contemporary violence associated with body hatred" (p. 55). Intersections of race, gender, sexuality, and body size are all central to body terrorism, as the justification for discrimination is based within bodies and experienced in bodies. The effects of body terrorism and society being organized by a hierarchy of bodies is not simply within the psyche of each individual who may or may not feel negatively about themselves due to these systems. For example, studies have shown that the fatter a person is, the more likely they are to experience employment discrimination (Puhl & Heuer, 2009). The effects of anti-fat bias are tangible and systemic.

Think of the Children

Children experience anti-fat bias acutely, as weight-based bullying is common in school settings, yet those responsible for these learning environments rarely take steps to destigmatize fatness and support fat students (Nutter et al., 2018b). Instead, fat children's bodies are used as a pawn of body terrorism. *Obesity* awareness campaigns have put up billboards with pictures of fat children using taglines such as "Warning: He has his father's eyes, his laugh, and maybe even his diabetes," and "Warning: Big bones didn't make me this way. Big meals did," and "Warning: It's hard to be a little girl if you're not" (Gordon, 2020, p. 38-39). The last statement is particularly telling of the intersections of anti-fat bias, misogyny, age, and anti-Black racism; fatness is often sexualized for those assigned female at birth (AFAB) stemming from how Black, AFAB bodies are over-sexualized and *adultified*, young people being perceived as adults (Strings, 2019). It is common for the *obesity epidemic* discourse to overemphasize the supposed negative effects of *obesity* on children, using children as a moral bargaining chip to further prove the biased point that fatness is inherently bad and unhealthy (Evans et al., 2008). The results of this discriminatory discourse are an increase in children being removed from stable and loving homes by social service agencies simply because the child is fat (van Amsterdam, 2013). Fatness in children is treated as neglect and a moral failing of parents, primarily single mothers who are more likely to have their fat children removed from their homes (van Amsterdam, 2013). This act of systemic violence perpetuates colonial systems that have been in place for hundreds of years, claiming that this state-sanctioned body terrorism is for the benefit of the children and families being victimized.

The Health Impacts of Discrimination

Fatness has become a convenient scapegoat for many health conditions, as well as increased mortality. However, the majority of research that claims fatness causes this cornucopia of disease fails to measure the impact of anti-fat bias on the health of their participants (Bacon & Aphramor, 2014). The research on health disparities between those with privilege and those who are oppressed is not new, and yet this is conveniently omitted from the public discourse about bodies and health. There is mounting evidence that the increased allostatic load from experiencing constant discrimination has much more of an impact on health than fatness (Bacon, 2020; Bacon & Aphramor, 2014; Gordon, 2020; Harrison, 2019; Lucas et al., 2016; Milburn et al., 2019; Nagoski & Nagoski, 2019; Smith, 2008; Tomiyama & Mann, 2013; Williams et al., 2016). It has also been shown that health disparities increase positively with multiple intersections of oppression (Milburn et al., 2019). Specifically, weight/ anti-fat bias, has been shown to negatively impact health more than fatness itself (Nutter et al., 2016). Anti-fat bias is positively correlated with weight gain, poorer nutrition, a decrease in exercise habits, depression, lower self-esteem, and negative body image (Puhl & Heuer, 2009). It can then be concluded that anti-fat bias and other forms of discrimination create ill-health, and that certainty cannot be claimed about the negative impacts of fatness or *obesity* supposedly measured in a vacuum devoid of anti-fat bias.

Healthism and Locus of Control

While anti-fat bias is still implicit and explicit in many individual attitudes and systems, some studies have shown that explicit anti-fat attitudes are decreasing in specific contexts. Elison and Çiftçi (2015) measured anti-fat attitudes in relation to the locus of control of fatness,

assessing how attitudes change when the fat person is held responsible for their body size or whether their body size is seen as outside of their control. Nutter et al. (2018a) corroborate these findings, showing that weight bias is less prevalent when *obesity* is framed as an uncontrollable disease instead of a personal failing. However, Elison and Çiftçi found that when measuring the locus of control of an individual's health, anti-fat attitudes were much higher. This is in alignment with Harrison's (2019) evidence that anti-fat bias and diet culture have shapeshifted from an overt disgust of fat bodies to an emphasis on pursuing health as a moral imperative. This intersects with ableism to allow those profiting from anti-fat bias and body terrorism to claim that they are helping and promoting health, all while continuing to conflate health and weight which perpetuates body-based oppression (Kinavey & Cool, 2019).

Healthism frequently manifests in modern-day *wellness culture* which is made up of pseudoscientific claims that repackage and appropriate Eastern medicine practices with an exorbitant price tag in order to profit off of vulnerable and ill people who are desperate for healing (Gordon & Hobbes, 2020-present). Moreover, wellness culture claims to be health-centric, yet consistently conflates health and thinness. This is acutely exemplified in Weight Watchers' 2018 rebranding, renaming the company as WW and adding the new tagline "wellness that works" (Gordon & Hobbes, 2020-present). Their marketing co-opted much of the language of intuitive eating and *Health at Every Size* (Bacon, 2008), yet their business model is still built on the pursuit of thinness (Gordon & Hobbes, 2020-present). Wellness culture culminates in companies parroting false claims about health, even going so far as to outright decry dieting, yet depending on anti-fat bias to keep their customer base dissatisfied with their bodies and continuing to purchase products and services from wellness companies (Harrison,

2019). Just as anti-Black racism now masks itself with anti-fat bias, anti-fat bias infiltrates systems and individuals under the guise of healthism.

Intersections of Body-Based Oppression

The paternalistic helping approaches taken towards fatness are mirrored in many other systems of power that overlap with anti-fat bias. Socioeconomic status and poverty are key intersections, along with race, that must be analyzed when addressing anti-fat bias (Puhl et al., 2020). It is worth noting that many of the disparaging stereotypes made about fat people, that they are lazy, sloppy, and stupid, overlap with attitudes about people experiencing poverty (Smith, 2008). The locus of control of oppression is internalized with poverty, just as it is with fatness. Those with low socioeconomic status are blamed for their poverty just as fat people are blamed for their fatness (Kinavey & Cool, 2019; Nutter et al., 2018b; Smith, 2008; Tomiyama & Mann, 2013).

As for the intersections of race, associations between anti-fat bias and anti-Black racism are so strong that it is difficult to separate the two when researching how they influence Black communities (Puhl & Heuer, 2009). This reminds researchers of the necessity to include assessment for both anti-fat bias and anti-Black racism when researching health, body size, anti-fat bias, and racism (Puhl et al., 2020). Current research has shown that when research on *obesity* is conducted in Black and Latino communities, the results are more likely to internalize the locus of control of *obesity* within their participants, claiming that poor food and exercise behaviours are to blame at a rate higher than when researching white populations (Campos et al., 2006). The same bias has been found when researching those with lower socioeconomic statuses, that their *obesity* and the negative effects of it are also a result of their bad choices

(Campos et al., 2006). Thus, the assumption that fat, poor, and racialized people are lazy, stupid, and incapable of making good decisions for themselves is perpetuated in the literature and systems.

Higher body weights are positively correlated with dieting behaviours, which offers a helpful lens when analyzing the intersections of class, body size, and discrimination. Studies have shown that dieting and disordered eating behaviours are positively correlated with food insecurity (Becket et al., 2017; Harrison, 2019). In addition, behaviour modification of eating and exercise to promote health have been shown to only benefit those with higher socioeconomic status while poorer people remain fat when employing the same behaviour changes (Aphramor, 2017). This begs the question as to why universal basic income is not being suggested as a cure to the *obesity epidemic*?

Unvictimizable.

Please note that this section mentions racialized violence, police brutality, and sexualized violence, which some readers may find disturbing and could cause distressing memories to resurface.

Another complicated and important intersection to discuss is that of race, gender, disability, and body size. This is exemplified in the media coverage surrounding the murder of Eric Garner (Ogden et al., 2019). In the years since his murder, Mr. Garner has routinely been blamed for his own murder due to his body size and disability, with claims being made that Mr. Garner would not have died from a lethal chokehold if he were not fat nor asthmatic (Morrow, 2017). In this instance, the ways in which the locus of control of fatness is internalized extends

to blame Mr. Garner for his own murder – implying that fat bodies must not only be responsible for themselves, but the violence enacted upon them. Morrow (2017) uses the term "unvictimizable" to describe how "Black people—of all sizes, but fat Black people in particular—are figured as innately disabled but also as invulnerable to disability, injury, or suffering" (p. 105). This is supported by ample medical research that shows how "half of white medical trainees believe such myths as Black people have thicker skin or less sensitive nerve endings than white people" (Sabin, 2020).

During the final weeks of writing this paper a 16-year-old girl named Ma'Khia Bryant was murdered by Ohio police. One Twitter user comments, "Child? Have you seen the video? She's huge. And wielding a knife at people. If it was your family getting attacked I'm sure you would want a cop to shoot too" (In Herbie's World, 2021). Ma'Khia was both Black and fat, and the rhetoric of adultifying Black children has intersected with her fatness to blame Ma'Khia, a literal child, for her own murder (Cineas, 2021). This white supremacist rhetoric is meant to absolve the police officer that murdered her and claim that somehow lethal force was necessary because of Ma'Khia's body size and skin colour. Even though she had a weapon, Ma'Khia was a child. She was murdered because she is Black, and she is being blamed for her own murder because she is both Black and fat.

The roots of anti-fat bias are once again found in anti-Black racism, as fatness is used as a reason to victim-blame people of all races who experience violence. This is particularly acute in the discriminatory belief that fat people cannot be raped because their fatness makes them so inherently undesirable that fat people must welcome any and all sexual contact. There are layers of implications to peel back in this bigoted thinking. First, claiming that fat people cannot

be raped equates violence and sex, claiming that the consent of a fat person is assumed at all times. Next, it implies that fatness is never desirable, and last, that the fat person is responsible and must be grateful for the violence they experience because they are responsible for their fatness. These ideas are subtle yet rampant, as illustrated in Canadian courts. In 2017, Quebec judge Jean-Paul Braun was trying the case of a 49-year-old taxi driver who sexually assaulted a 17-year-old girl, and said that "she's a young girl, 17. Maybe she's a little overweight but she has a pretty face, no? …She was a bit flattered. Maybe it was the first time he showed interest in her" (Kassam, 2017). This aligns with Gotovac and Towson's (2015) research showing that survivors of sexualized violence who are fat are more likely to be victim-blamed when reporting sexual assault. This connection between Blackness and fatness being unvictimizable is apparent when putting these ideas in their historical context of colonization and the trans-Atlantic slave trade. White supremacy required fat, Black bodies to be systematically dehumanized to justify violence towards African peoples (String, 2019). It is imperative to acknowledge this historical context to recognize that ideas about fatness being bad or detrimental to health are not founded in science or medicine, but in systemic anti-Black racism and violence.

Modern Colonialism

While the focus of this paper is the intersection of anti-fat bias and anti-Black racism, it is imperative to reference how anti-fat bias has also been used to systemically oppress Indigenous populations. Anti-fat bias is an inherently colonial idea, and was used by white, European men to justify the enslavement of Black African peoples to then colonize Indigenous lands and bodies (Gillon & Pausé, 2021; String, 2019). The social construct of health has been determined by "white supremacy, colonization, patriarchy, and capitalism" (Gillon & Pausé,

2021, p.2) to create the modern perception that good bodies are closest in proximity to both whiteness and thinness (Kinavey & Cool, 2019; van Amsterdam, 2013). Prior to colonization, the concept of weight loss for health was not part of many Indigenous cultures (Warbrick et al., 2018). Fasting has long been tied to many spiritual practices, but chronic dieting and pursuit of weight loss to prove one's wholesome morals and worthiness is a direct product of Protestantism, white supremacy, and colonization (Strings, 2019).

In colonial countries like Canada and the United States, as well as Aotearoa New Zealand, this centuries-long history of white people violently oppressing Indigenous and Black peoples by claiming to help these communities is repeated through the *obesity epidemic*. Those in positions of power, whether it be government organizations, helping professionals, or academia, go into Black and Indigenous communities to research or help these communities by educating them about the negative effects of *obesity* (Cassidy et al., 2018). Warbrick et al. (2018) highlight that this approach continues to individualize and problematize Indigenous bodies instead of focusing on the oppressive systems that create ill-health in their communities. Moreover, they draw the parallels from early colonial mindsets that framed Indigenous peoples as ignorant, less evolved, and less sophisticated, to modern day *obesity epidemic* campaigns that endeavor to educate Indigenous communities on how they should change their behaviours. Hunt (2016) highlights this in the context of Canada, that colonization was dependent not only on the colonization of lands, but also Indigenous bodies. Indigenous bodies were strategically targeted "as sites of dispossession – nonconsensually renaming, regendering, and racializing Indigenous children while denying them their cultural roles and teachings" (p. 5). The ways in which systems of power continue to individualize and target racialized communities

with anti-*obesity* education is actively serving to maintain white supremacy and further colonialize Black and Indigenous bodies and communities (Smith, 2008; Strings, 2019; van Amsterdam, 2013; Warbrick et al., 2018).

Applicability to Research

While these predatory, discriminatory systems are constantly reproduced, it is important to note that it is not done with ill-will or intent. Rather, many researchers have bought so deeply into the myth that fatness is inherently unhealthy that they are earnestly trying to help these communities. For example, Cassidy et al. (2018) focussed their research on eating habits of Black youth and concluded that culturally specific psychoeducation is required to engage caregivers and help Black youth reduce their rates of *obesity*. Sabik and Versey (2016) conducted a similar study, instead focussing on delivering psychoeducation about the dangers of *obesity* to Elder Black women. Though well-intentioned and approached from an ethic of care for supporting and protecting Black youth and Elders, neither of these studies factor in the systemic discrimination of anti-fat bias and anti-Black racism that are likely impeding the health of the participants. Both perpetuate the individualization of *obesity* through pathologizing participant's bodies, and the colonial, white supremacist idea that these communities need educating.

This chapter has shown that little connection between anti-Black racism and anti-fat bias exists in the literature and how continuing to root anti-fat bias in the historical context of anti-Black racism can support researchers and practitioners to resist individualizing and pathologizing clients based on the hierarchy of bodies. The relationship between systemic discrimination and disease were explored to show how a broader, non-pathologizing lens must

be taken to support clients who are fat, Black, or live at the intersection of those two identities. This critical review has shown how prolific anti-fat bias is and how tangible its impacts are on the well-being of fat people. Despite the broad reach and influence of anti-fat bias, the literature has shown that few studies account for anti-fat bias when researching the effects of body size on health, and mental wellness. This synthesis allows researchers and practitioners to critically examine their complicity in perpetuating both anti-fat bias and, thus, anti-Black racism and modern-day colonialism.

Chapter 3: Discussion and Implications for Counselling Practice

Chapter two offered a review of the literature as it pertains to the intersection of anti-fat bias and anti-Black racism from a broader societal and historical lens. This chapter will focus on the applicability to counselling practice and give tangible recommendations for how to incorporate these ideas to best support clients, counsellor development, and communities at large. The ways in which counselling practice has perpetuated oppression of fat, Black bodies will be reviewed and myths of working with fat, Black bodies will be addressed. Self-reflection questions will be provided for practitioners to consider how they perpetuate anti-fat bias as it intersects with anti-Black racism in their work with clients.

There is a growing body of academic research highlighting the unbridled anti-fat bias that exists in systems of power. Fatness has long been ignored as an important intersection of identity politics (Nutter et al., 2018b), with many who have left-leaning political beliefs perpetuating as much discrimination towards fat people as those with centrist or right-leaning political beliefs (Your Fat Friend, 2019). However, this is beginning to shift thanks to the tireless work of many fat liberationists, anti-diet advocates, decolonial academics, and antiracist leaders. The undercurrent of anti-fat bias that operates just below the surface of most people's awareness is beginning to be recognized. It was expected that the literature review would yield a dearth of research on anti-fat bias, yet the past decade has shown a distinct shift in cultural and academic attitudes towards fatness.

While the majority of research on fatness is still relegated to *obesity* studies (Puhl & Heuer, 2009), an awareness of anti-fat bias is slowly growing within medical research and practice. The locus of control for fatness is being critically analyzed within medical research

while fat studies researchers continue to frame fatness and health as social constructs, like race and gender, created to marginalize and exert white supremacist power. Strings' (2019) historical exploration of anti-Black racism and anti-fat bias has proved to be an invaluable missing link to understand how modern anti-fat bias and the pro-thin ideal came to be so prevalent. The importance of her work cannot be overstated. Her conclusion that anti-fat bias is a function of anti-Black racism and colonization/colonialism is rare, and this connection between these marginalized identities must be maintained. These ideas are rarely connected and are treated as entirely separate identities that may intersect. While they do intersect, decontextualizing anti-fat bias from anti-Black racism is what allows fat liberationist ideas to center whiteness and be appropriated into the now mainstream movement of body positivity (Johnson, 2019).

Limitations, Constraints, and Recommendations for Research

This project was limited by the dearth of research that focusses specifically on the intersections of anti-Black racism and anti-fat bias, especially in the context of counselling practice. There is an ample body of research from fat studies to draw on, yet awareness of anti-fat bias/weight stigma in other faculties is still limited. Understandings were gleaned from what exists in the literature but were largely dependent on what the literature left out, creating room for subjectivity and interpretation. Disability is an important intersection that relates closely to fat liberation, yet the scope of this paper did not allow for this intersection to be explored. Disability studies and activists have done vitally important work around social determinants of health, particularly as it relates to the concept of healthism and the idea that health can and should be pursued at all costs. From an intersectional feminist and anti-

oppressive perspective, it is necessary for the author to self-locate within this work and from this, acknowledge the inherent subjectivity of this research (Arthur et al., 2017). While decentering whiteness is central to this paper, this is not entirely possible due to my own whiteness as the author. My own unconscious biases have still shown up in this paper, and though Black, anti-fat bias thought leaders are central to the research, many white authors were still included.

Gender

This paper has not taken an explicit stance on gender and it is important to note that the majority of the research on body size, specifically as it pertains to self-image, focuses on cisgender women. This is unsurprising, as anti-fat bias intersects with misogyny in patriarchal systems to limit the range of acceptable body size for cisgender women more than it does for cisgender men. However, it is worth noting that cisgender men are increasingly targeted and objectified by anti-fat bias and Eurocentric beauty standards (Arthur et al., 2017). The research also entirely ignores the experiences of Trans and gender non-conforming people, and continues to perpetuate the inaccurate and discriminatory colonial construct of gender binaries. This paper is limited in its ability to accurately reflect the experiences of diverse genders as they intersect with anti-fat bias and anti-Black racism.

The BMI

Future research on anti-fat bias, weight stigma, and how body size correlates to health outcomes would be strengthened by eliminating the use of the BMI. The BMI perpetuates disinformation about fatness, race, and health. In an anti-fat society hypervigilant about healthism, the BMI creates a convenient categorical system for anti-fat bias to delineate which

bodies are deserving of basic human rights, care, and dignity, and which are not. Along with the BMI, the categorical names it uses to pathologize body size should also be rejected. Phrases like *normal weight*, *overweight*, and *obese* inherently perpetuate the hierarchy of bodies (Taylor, 2018), creating a moralistic lens through which all bodies are viewed. The removal of the BMI and eliminating *obesity* language from both research and health care would mark a significant shift away from systemic anti-fat bias.

Uprooting Anti-Black Racism and Anti-Fat Bias in Counselling Practice

Counsellors are uniquely positioned to advance social justice in our work (Kinavey & Cool, 2019; Smith, 2008). The role of mental health and mental wellness professionals should never be to help clients adjust to an unjust world, but rather, to change the conditions of clients' lives to promote justice and decrease suffering. The work of challenging anti-fat bias and anti-Black racism in counselling requires attention at three levels: personally, professionally, and systemically, all of which must be adopted simultaneously. Personal and professional growth cannot replace the dire need for systemic change. To focus personal and professional development would be to individualize this work, which would uphold white supremacist power structures. It is worth noting that counsellors do not exist in a vacuum and any personal challenges to anti-fat bias and anti-Black racism could create opportunities for professional and systemic activism.

Meaningful changes for counselling practice, ourselves, our clients, and our communities are possible if our approaches remain intersectional and multi-faceted. It is highly recommended that counsellors hoping to adopt fat inclusive ways of working seek out the writing of Kinavey and Cool (2019), *The Broken Lens: How Anti-Fat Bias in Psychotherapy is*

Harming Our Clients and What To Do About It. They offer an intersectional analysis of anti-fat bias in psychotherapy and 10 tangible ways that counsellors can make their practice more inclusive. The following recommendations will incorporate some of their ideas, but not comprehensively.

Accept Thinness as a Privilege

Counsellors must understand our own intersections of privilege and oppression in order to serve clients more justly and ethically (Kinavey & Cool, 2019; Reynolds, 2019; Smith, 2008). This requires us to do the difficult work of understanding where our body locates us in the hierarchy of bodies (Taylor, 2018) and what privileges and oppression we may face as a result of this social coding, regardless of any feelings we may have about our bodies. To uproot anti-fat bias and anti-Black racism, thinness must be accepted as a privilege (Nutter et al, 2018). This can be difficult, as each person has internalized anti-Black and anti-fat biases when it comes to perceptions of their bodies. Shifting the focus from personal feelings to systemic oppression can support counsellors in better understanding their body size privilege. This does not require counsellors to view themselves as thin, but to accept that they do not experienced the same marginalization and indignities that fat people face when it comes to housing, employment, medical care, travel, and interpersonal relationships (Gordon, 2020). Unfortunately, anti-fat bias is well documented within counselling practice and mental health professionals are encouraged to perpetuate myths about body size that, when viewed through a systemic lens, actively oppress and increases the suffering of our clients (Kinavey & Cool, 2019; Nutter et al., 2018b).

Some questions to help counsellors identify whether or not they possess thin privilege are:

- Do you see your body size reflected positively in media?
- Can you walk into an average clothing store and find affordable and stylish clothing in your size?
- How often do friends, family, and co-workers make comments about your body, eating habits, or exercise behaviours?
- Can you sit comfortable on a bus or a plane?
- Have you ever been denied transportation because of your body size?
- Have you ever been denied a job, promotion, or housing, or medical care due to your body size?
- Have you ever had health concerns ignored and been told that your illness is due to your weight?

Honour the Intersections, Resist Pathology

Self-location as well as honouring clients' intersections of identities are essential to uprooting anti-fat bias in the counselling context. Racial and body size identities are central to this process, so as not to obscure the anti-Black origins of anti-fat bias. To not name the racialized origins of anti-fat bias is to obscure the violent history that provides the foundation for our modern conceptualizations of bodies. We must resist colluding with white supremacy and anti-fat bias and can do so by naming systemic anti-fat bias and its roots in anti-Black racism instead of locating the problem of negative body-image and discrimination within the

minds of our clients. It is essential to decenter whiteness and understand that negative body-image and anti-fat bias can show up differently in Black clients. It is common for white, feminist counsellors to assume that we cannot enact harm because we operate from a feminist lens, yet studies have shown that white feminist counsellors enact racialized microaggressions towards their Black clients (Mazzula & Nadal, 2015). The white, liberal idea of distancing oneself from overtly racist white people must be resisted (Tuck & Yang, 2012), as it places the focus on others instead of continually reflecting on one's own privilege. This perpetuates those with privilege to move towards innocence, absolving themselves from any risk of perpetrating discrimination (Tuck & Yang, 2012). In reality, counsellors are not immune from the discriminatory conditioning that all receive in an oppressive society. Thus, the work is never done, and no level of awareness around social justice provides a free pass to become complacent.

An intersectional lens of systemic social justice can be adopted in work with clients. It does not benefit clients to individualize and internalize their experiences of systemic oppression, and to use one's position as a counsellor to do so would enact further discriminatory violence. Feelings of anger and unrest should not be approached with attempts to stabilize or move away from these experiences. Instead, we can support clients in acknowledging the purpose of their anger and unrest and moving into a place of action to address the roots of this suffering instead of the individual consequences. This gives counsellors the opportunity to reflect on how we can stand in solidarity with our clients instead of attempting to fix their distress. This requires counsellors to be comfortable with clients expressing activating emotions, but also to be wary of stereotypes that cause fat and Black

people to be perceived as threatening (Morrow, 2017). This requires counsellors to stay aware of their own biases that could be generating discomfort and ask ourselves what information we might be missing for the client's responses to make sense to us. This can be done relationally in sessions, but also requires a foundational understanding of systemic oppression, so as not to expect clients to educate us about the discrimination they face.

Counsellors can reflect on the following questions:

- How are power and privilege showing up in session?
- How are my intersections of identity influencing how I perceive this client?
- What might my intersections of identity prevent me from understanding about clients who have different identities than me?
- What part of the client's experience does not align with my own and what might I need to research as a result of this?

Address Your Own Internalization of Anti-Fat Bias and Anti-Black Racism

While anti-fat bias certainly affects fat and Black people most acutely, particularly at the systemic level, it is important to recognize that people of all body sizes and races can internalize anti-fat and anti-Back ideas. Because counsellors bring their entire selves into their work, and also because body size is an immediate self-disclosure, it is both personally and professionally beneficial for counsellors to commit to their own self-image work. Not questioning one's internalization of white supremacist standards of beauty is what leads counsellors to harm their clients by projecting their own body image, eating, and exercise concerns onto their clients

(Bennett, n.d.). Working on one's own internalization of anti-fat and anti-Black attitudes can be a way to uproot implicit bias that is inevitably present in work with clients.

Counsellors can reflect on the following questions:

- How would you describe your relationship to your body, eating behaviours, and exercise behaviours?
- What kind of hypervigilance do you hold around your body, eating, and exercise?
- Where did you learn these ideas? What sources do you look to for health advice?
- Are those sources inclusive of all bodies and do they readily recommend weight loss?
- Which parts of your body do you dream of changing?
- How did you learn that you need to change your body?
- How have you embraced concepts of body neutrality and gratitude towards your body?

Counselling Education Programs

It is difficult for fat people seeking care to find a doctor, nurse, dietician, or counsellor that do not exhibit overt anti-fat bias (Alberga et al., 2019). It has been well documented that education and training programs for these professionals are failing to teach about anti-fat bias, and the societal messages define fat people as "disgusting, sloppy, dishonest, or unlikable" (Alberga et al., 2019, p. 636) seep into the ways that medical and mental health professionals work with fat people. Many researchers and advocates have made calls for training programs to teach their students how to recognize and work against anti-fat bias (Alberga et al., 2019; Nutter et al., 2018b; Puhl & Heuer, 2009). The lack of education around anti-fat bias results in the continued oppression of fat and Black people, as clinicians are less likely to diagnose eating

disorders in racialized populations (Gordon et al., 2010), fat people are told their fatness is a moral failing and their body size is pathologized (Kinavey & Cool, 2019; van Amsterdam, 2013), and Black clients are more likely to experience microaggressions from white practitioners (Mazzula & Nadal, 2015). This shows the desperate need for schools to teach about anti-fat bias so that the white supremacist messaging about fat bodies can be disrupted.

My personal experience in a counselling program confers these points. I have encountered anti-fat bias from multiple professors who are social justice oriented and have decades of experience in the field. The first instance was when my class was assigned a counselling demonstration video about solution-focussed therapy where the therapist managed to weave startling anti-fat bias into his points. In this demonstration (Milton H. Erickson Foundation, 2013), Bill O'Hanlon shares his technique of working with clients who are single and wanting to be in a relationship, saying,

> I used to when I was doing couples therapy or sometimes individual therapy with someone who wanted to be in a relationship. And they would say, "Oh, nobody wants me." … I'd say, here's your assignment, you're to go to the shopping mall… and you just sit there and look at the people that are in relationships. Just look at all the people that are in relationships. Some of those people are terrible looking… how did they actually have sex? With the size of their stomachs I don't know how their genitals got together. And they would come back and tell me these stories and said that was the best assignment you ever gave me… I'm sure I can get married now, and I am sure I can get into a relationship (0:24:27).

O'Hanlon perpetuates harmful anti-fat bias myths: that fat people are unlovable, that fatness is inherently abhorrent, ugly, and undesirable, that fatness is asexual, and that thin people should make themselves feel better by comparing themselves to fat people. O'Hanlon did this on stage at a conference, in front of an audience of mental health professionals who laughed along with him. My professor watched this video and saw no issue assigning it to a cohort of counsellors in training. I was trying to learn about solution-focussed therapy and instead was forced to experience anti-fat violence. The video was removed from the course once I brought this to the professor's attention, and yet, the only systemic analysis or reflection on anti-fat bias in counselling offered to the class came from my own participation, not the professor. This is consistent throughout my three years of training.

While this was the most overt example, I have had professors invalidate anti-fat bias microaggressions I have shared in class, telling me in front of the class that I was simply interpreting the situation in that way and it likely was not discriminatory. I have sat through professors explaining their highly restrictive, self-starvation diets and journeys with weight gain and weight loss in great detail, and I have had professors and fellow students treat my questions about how to support fat clients as personal attacks. My program is known for being exceptionally oriented towards social-justice, and yet anti-fat bias persists.

Counsellors who find themselves in academic settings can ask themselves:

- How is anti-fat bias is addressed in this system?
- Is it connected to anti-Black racism?
- How can you encourage this systemic thinking in counselling students?

- Are you centering the voices of fat, Black people when doing this work?
- Are these biases contextualized in larger systems of body terrorism (Taylor, 2018)?
- Is this being done in a way that is sensitive to fat and racialized students?
- What decolonial and antiracist practices is your academic institution engaging in and how do these have a tangible positive impact on racialized students?

Self-Compassion in the Social Context

Studies have shown that self-compassion and environments that are accepting of all body sizes are positively correlated (Puhl et al., 2020), suggesting that challenging anti-fat bias could support counsellors in decreasing the suffering of their clients. It is important to note that, while this approach is acutely important for work with fat clients, people of all body sizes experience the impacts of anti-fat bias and those with thin privilege also need support in liberating themselves from the pressures of anti-Black and anti-fat ideals. Similarly, white counsellors cannot reserve challenging systemic anti-Black racism for work with only Black and racialized clients. Therapeutic healing for thin, white, cisgender women cannot be found while maintaining anti-fat and anti-Black approaches to counselling. It is unethical to support clients with privilege to feel better at the expense of a marginalized group and it is crucial to acknowledge white supremacist functions of anti-fat bias and anti-Black racism in work with clients of all body sizes. Kinavey & Cool (2019) advocate for promoting body liberation work in all areas of therapy and not relegating this approach to only body image concerns or eating disorders. To confine addressing anti-fat bias and anti-Black racism to body image and eating disorder specializations continues to locate the problem within the individual and incorrectly

connects body size to behavioural changes. Therefore, counsellors can create the conditions for all clients to embrace self-compassion by uprooting anti-fat bias and not pathologizing bodies.

Counsellors can reflect on these questions:

- How can I honour client's individual experiences of discrimination while acknowledging the universality of human suffering?
- How can self-compassion be put into a context of systems of oppression?
- How can I make my practice inclusive through practice and physical space accessibility of all bodies (Kinavey & Cool, 2019) to set a better foundation for clients to adopt self-compassion?

Fat Does Not Equal Trauma

There is a common myth in counselling practice that fatness is a protective result of a person experiencing trauma, and that once the trauma is addressed the person will lose weight (Kinavey & Cool. 2019). This perpetuates the idea of compulsory thinness, that all fat people are actually thin people waiting to be freed from their prison of fat. Treating fatness as a result of trauma continues to frame fatness as a problem and locate its origins within the mind and body of the fat person (Kinavey & Cool, 2019; Nutter et al., 2018b; Tomiyama & Mann, 2013). Fatness should not be pathologized nor framed as a temporary state. Adopting a Health at Every Size (Bacon, 2008) approach to counselling will support counsellors in de-pathologizing body size and accepting that bodies of any size can be healthy and well (Elison & Çiftçi, 2015). Thus, counsellors can shift the focus away from weight as a determinant of health and support

clients in adopting behaviours and perspectives that promote health behaviours that is detached from weight outcomes.

Counsellors can reflect on the following to better understand their own biases around health and fatness:

- When you imagine a healthy person, what is their skin colour, body size, ability, gender, height, age, socioeconomic status, and citizenship?
- How does this imagined person achieve health?
- Are health behaviour changes accessible to the broader population?
- When you imagine an unhealthy person, what is their skin colour, body size, ability, gender, height, age, socioeconomic status, and citizenship?
- What behaviours do unhealthy people engage in?
- What assumptions do you make about healthy and unhealthy people's character?
- How is your concept of health connected to morality?
- How do your attitudes shift when thinking about someone who intentionally does not pursue health?
- Does someone need to pursue health in order to be deserving of dignity and respect?

Promoting Dieting is Unethical

Counsellors are obligated to promote the well-being of clients in a culturally safe way that also promotes the well-being of client communities. Promoting dieting, thus anti-fat bias and anti-Black racism, perpetuates weight stigma which increases likelihood of depression, low self-esteem, poorer body image, eating disorders, and decreases exercising behaviours

(Harrison, 2019; Puhl & Heuer, 2009). There is no long-term means for weight loss that is both safe and effective (Campos et al., 2006). Counsellors must resist offering short-term solutions through dieting that perpetuate long-term suffering and dieting/weight cycling in clients. While it is true that placebo and nocebo effects are strong, the vast majority of people are left feeling worse and experience poorer health when a diet inevitably fails, as all diets are designed to do (Harrison, 2019).

The majority of modern diets recommend a caloric intake that is lower than the seminal Minnesota Starvation Experiment of 1945 (Harrison, 2019), led by Ancel Keys, father of the BMI. This study showed the detrimental effects of starvation on both physical and psychological well-being and the lasting hypervigilance created around food when limiting its intake (Harrison, 2019). It would be unethical to reproduce this study today and so, knowing that most modern diets are around the same caloric intake as this starvation study, why is dieting still seen as an ethical way to support clients? Counsellors must understand that dieting takes many forms and can be present whether or not the client names a specific diet plan they are participating in. Hypervigilance and restrictive behaviours around food are good indications that dieting is present.

Although dieting is harmful and should not be recommended by counsellors, the reality is that many clients seek counselling to support them with weight loss and dieting. The bodily autonomy of clients must be respected at all times, requiring counsellors to take a nuanced approach in order to support clients in their autonomy, but to not perpetuate harmful practices for their clients. It should also be noted that dieting, bariatric surgery, and intentional weight loss can be a form of self-protection for fat clients who choose to pursue changing their bodies

to seek safety in a world that abhors fatness. Client's choice to attempt weight loss can be honoured as self-protection while still locating the shame associated with fatness in oppressive systems, not individuals (Kinavey & Cool, 2019).

Counsellors can ask themselves:

- How can I honour the bodily autonomy of my clients while accurately framing the locus of control of body size outside of behavioural changes?
- How can I support clients in decreasing their hypervigilance around food and exercise?
- How can I support clients in focussing on health outcomes instead of appearance outcomes?
- How can I support clients in moving and nourishing their bodies from a place of joy instead of punishment or repentance?

Systemic Implications

Body size is not included in the equality rights section of the Canadian Charter of Rights and Freedoms (1982), nor is there any federal legislation in the United States that makes weight discrimination illegal (Puhl, 2019). Engaging in political, social justice-oriented action is necessary to uproot anti-fat bias and anti-Black racism. Counsellors have the opportunity to engage with activist communities as well as use their professional position to lobby governments to adopt legislation that protects fat people and addresses anti-fat bias. However, when advocating for fat people, whiteness must be addressed, and the needs of racialized communities prioritized. Centering the needs of Black communities when engaging in anti-fat bias advocacy means addressing the systemic violence disproportionately enacted towards

Black and racialized communities. This systemic violence is enacted by institutions of medicine, policing, education, employment, government, housing, and mental health, among others. Systemic racialized violence cannot be ignored when working towards body-based justice in counselling else counsellors risk perpetuating systems of white supremacy that only protect white, fat bodies.

There are difficult questions that counsellors and those in mental health professions need to ask themselves given that the majority of mental health professionals are white (Mazzula & Nadal, 2015; Lin et al., 2018). A main function of whiteness is that it renders itself invisible by claiming it is the norm (DiAngelo, 2018; Mazzula & Nadal, 2015). This means that white people, including white mental health professionals, rarely have to confront their own racial identity and how it implicates them in systems of power. Making an altruistic choice to work in a helping profession or already having some awareness of systemic issues does not immediately mitigate how a white counsellor's whiteness will influence their work (Mazzula & Nadal, 2015). Therefore, the following questions are specifically written for white counsellors and not for Black, Indigenous, or other racialized counsellors, as the unlearning necessary for ethical practice is different based on racial identity (L. Gunderson, personal communication, May 4, 2021). My position as a white woman means that I am not qualified to give recommendations for how racialized counsellors can alter their practice to address systemic discrimination.

White counsellors can ask themselves:

- How can I decenter whiteness in my work, especially with white clients?

- How can I resist the immobilization of white guilt and instead give up power, resources, and opportunity to Black, Indigenous, and racialized communities?
- How is power showing up in my work?
- How have I been able to navigate my life ignorant of systemic white supremacy?
- How will I address the violence inherently tied to my whiteness when working with racialized clients and colleagues?
- How can I resist performative allyship and instead adopt the position of a co-conspirator and disruptor with those who are already engaging in antiracist work?
- How can I organize with other white counsellors to support one another in antiracist work and discuss how we can use our positions toward racial equity?
- How can I continually educate myself about the global and local functions of white supremacy?
- What trainings can I engage with to prioritize antiracism and decolonization as part of my professional development?
- Which branches of my counselling regulatory body do I need to become involved with to advocate for Black and fat people?
- How are my actions supporting self-determination of racialized and fat communities?

Adopt Social Justice as a Form of Self-Care.

Reynolds (2019) frames burnout in the fields of therapy and community work not as an individual problem that can be remedied with enough yoga or hydration, but as spiritual pain that can only be addressed through systemic social change. She explains how the most significant negative impacts on therapists do not come from work with clients or peers, but

from having to navigate unjust systems. Tangibly this requires counsellors to take an active role in unlearning the myths of fatness and Blackness that white supremacy has spread throughout our institutions, especially mental health. Anti-fat and anti-Black attitudes are subtle and pervasive; therefore, counsellors must be persistent in their effort to think critically and understand their biases.

Though counselling often has a specific focus on social justice, anti-fat bias is rarely included as an intersection of oppression. This omission renders racial bias analysis less nuanced and more superficial, ignoring how anti-fat bias is a function of anti-Black racism. To broaden one's lens and contextualize individual suffering within systemic oppression is to accurately locate client's problems within navigation of systems rather than pathology. When this is done, white supremacist individualization is resisted. Doing so allows counsellors to highlight the resistance that clients engage in on a daily basis as they survive and thrive within oppressive systems.

Counsellors may ask themselves:

- How does locating problems within systems alleviate pressure on myself and on clients?
- How can I support myself, my peers, and clients in adopting individual and systemic social-justice strategies to promote well-being?
- How can I honour the everyday resistance of myself, my peers, and my clients?

Conclusion

This paper outlined how the foundations of much of the research on body size is flawed by relying on outdated tools, like the BMI, that perpetuate anti-fat bias and anti-Black racism.

Anti-fat bias has been shown to be deeply entrenched in the research, pathology, and treatment of bodies that are fat, Black, and intersections of the two. The intersection of anti-fat bias, anti-Black racism was explored in the context of socioeconomic status and parallels between these forms of oppression were drawn. The dangers of prescribing dieting and weight loss were investigated and the direction of the correlational relationship between fatness and disease was questioned. An intersectional and systemic lens was taken when exploring the impacts of discrimination on individual and communities' health. It was found that modern campaigns fighting the *obesity epidemic* are a way for white supremacist systems to perpetuate the colonization of racialized bodies. Further evidence for the roots of anti-fat bias being found in anti-Black racism were discovered and the ways in which this historical context influences modern perceptions and treatment of fat bodies was established. Recommendations for counselling practice were then drawn from this information and promoting diets in the counselling context was established as unethical. Strategies for promoting social justice in counselling through individual, professional, and systemic actions were described and reflection questions about how counsellors can address anti-fat bias and anti-Black racism were provided.

The intention of this paper is to deconstruct the pseudo common-sense claims made about fatness to reveal the insidious nature of anti-fat bias's roots in anti-Black racism and how medical and mental health institutions perpetuate discrimination in the name of helping. The contextual analysis provided through reviewing literature in the faculties of medicine, fat studies, social justice, sociology, history, and counselling deepens the historical context of anti-fat bias and its inherent relationship to anti-Blackness. Individualization of these concepts creates space for whiteness to be centered when challenging anti-fat bias, which will inherently

prioritize thinness since the dichotomy of white/thin/moral versus Black/fat/immoral is so firmly rooted in collective perceptions of bodies in a white supremacist society. Continued research on these intersections of identity and oppression are desperately needed as the roots of these concepts and impacts of discrimination are far reaching. The demonization of fatness can no longer be accepted and must be uprooted to disassemble the ways in which anti-fat bias is used to enact modern-day colonization in Black, Indigenous, and racialized communities. Ideas of helping must be analyzed in a historical context that acknowledge the ways in which power and privilege function within modern systems.

Counselling is never a neutral process, and through work with clients, counsellors can choose to perpetuate oppressive systems or externalize them by resisting victim-blaming attitudes towards their fat clients. Whether or not this work has convinced you to adopt fat liberation and antiracist ways of working, this shift is slowly but surely occurring. The body of research focused on de-pathologizing body size is growing and public opinion continues to change around concepts of fatness thanks to the labour of many activists working from the intersections of their own identities. The foundations for adopting social justice perspectives in counselling practice are strong (Reynolds, 2019), which creates hope that one day the relationship between anti-fat bias and anti-Black racism will be commonly understood so that they can be mutually uprooted from systems of power and counselling practice. If you read this paper and take only one idea away, let it be this: to perpetuate anti-fat bias is to perpetuate anti-Black racism.

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