Thinly Veiled Oppression: Anti-Fat Bias and the Need for Revolution in Therapeutic Practice

By

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Abstract

The oppression of fat bodies has been insidious in its harm to women's mental health since the 19th century. Systemic body-based oppression is expressed through, and upheld by, the complicity and bias enacted by the health industry and psychotherapeutic tenets. This paper explores the racist roots of anti-fatness and the violence and control levied against fat women. Language is examined, exposing the origins of slurs commonly used such as 'obese,' and giving voice to individual identities. The experiences of fat women in healthcare are shared through an investigation of the medical industrial complex and the long-standing history of bias in psychology. Current approaches including health at every size, weight neutrality, and queering therapy are analyzed with a fat liberationist lens. Resources are then offered in response to this research, including social justice-based steps for counsellors based on the radical resistance of fat activists to revolutionize care and clinical implications for work with fat clients.

Keywords: anti-oppression, anti-fat, fat liberation, body-based oppression, body image

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Chapter 1

Topic Overview

This capstone is in response to the destructive impact that the oppression of fat bodies has on women's mental health and the radical resistance of fat liberation activists to revolutionize care. The systemic oppression is expressed through, and upheld by, the complicity and harm enacted by the health industry and psychotherapeutic tenets. While gender is expansive, this capstone explores the specific gendered aspects of anti-fatness as experienced by women, a term inclusive of trans and cis women and other people oppressed by misogyny (Ricketts, 2021). In this chapter I will provide historical context for this issue, state the significance of this topic as it relates to therapeutic practice, identify my personal stance, define key terms, declare theoretical lenses to be used in analysis, and provide an overview of chapters two and three.

Context of Anti-Fatness

Aesthetic standards for women's bodies and universal beauty ideals have dramatically changed over time and across cultures. The first 3-D ancient statue of a human being is believed to be a fat black woman (see Appendix): the Venus of Willendorf was "carved nearly 30,000 years ago" by prehistoric "black homo sapiens, migrants from Africa and the first inhabitants of Europe" (Shaw Nevins, as cited by Luna, 2021, para. 3). This was during the Upper Palaeolithic era, or the Old Stone Age, just after Neanderthals disappeared from fossil records, and where engraved/painted images in caves evolved into sculptures made out of clay, stone, bone, and ivory (Oxford Reference, 2012). In fact, history is filled with fat-bodied depictions of pharaohs, monarchs, deities, etc. that represented a range of positive traits such as fertility and prestige

(Harrison, 2019). The modern medical industry—an extension of patriarchy, capitalism, and misogynoir—will have people believe that fatness is a result of excess and the moral failings of women in today's culture. This statue unequivocally proves that fatness has always existed; fat bodies have only recently been vilified and pathologized by racist colonial scientific literature, with thinness enhancing the white supremacist agenda (Luna, 2021). Strings (2019) confirmed this purposefully crafted false narrative, asserting that the use of the Black feminine archetype made "fatness an intrinsically black, and implicitly off-putting, form of feminine embodiment in the European scientific and popular imagination" (p. 89).

As fat bodies have been violently policed and oppressed throughout colonial history, women who have been inordinately affected have been working towards liberation (Ponterotto, 2016). The current Fat Liberation movement in North America began in the 1960's with the first wave of Fat Pride and Fat Acceptance, with Jewish lesbian politics acknowledged as the origins of the rise of fat feminism (Tovar, 2018). The work to dismantle fat phobia has been organized by Fat Liberationists who understand the pervasive and powerful structures in place that harm fat bodies, especially fat women. Fat activism was a "queer political movement [that] had an anti-assimilationist framework", and this ethic of freedom threatened heteronormativity (Tovar, 2018, p. 92). Simon (2019) built upon Susie Orbach's famous 1978 insight of fat being a feminist issue, stating that "fat is also a queer issue, and a racialized issue, and an issue of class—because fatness is inseparable from all other intersections of identity" (Simon, 2019, para. 1).

Naomi Wolf (1991) connected these overlapping layers of oppression in her haunting statement about women's obedience: "dieting is the most potent political sedative in women's history; a quietly mad population is a tractable one" (p. 187). Anti-fatness and diet culture are violent tools of control used on women through racist rhetoric and social hierarchy, enacting

"bigotry that positions fat people as inferior and as objects of hatred and derision" (Tovar, 2018, p. 17). The rhetoric conflates anti-blackness with morality, and the social hierarchy is predetermined by patriarchy and sexism to suppress women's agency.

A delineation between *body image* and *body-based oppression* is critical for fat-positive work. Fat is not a feeling. Put simply, "body image refers to how each of us individually feel about our own bodies. Body-based oppression is about how the world around us treats our bodies" (Gordon, 2020b, para. 6). Body-based oppression is the systemic oppression a person faces based solely on their body, including size, race, gender, ability, et cetera. Thus, body image impacts every person, however body-based oppression is only experienced by those with bodies that deviate from the 'ideal' (e.g., bodies that are not straight-sized). Straight-sized is commonly referred to as up to a US women's size 12; it is essential to note that this is not an inclusive scaling system (Zoller, 2021). The spectrum of fatness, created within the fat community for self-identification, further classifies bigger bodies into small fat, mid-fat, large fat, superfat, and infinifat to denote fat privilege (G., 2021; Zoller, 2021; see also Gay, 2017). The categories exist on a spectrum: as the size and weight of a person's body increase, the barriers that a person faces due to anti-fatness also increase (G., 2021; Zoller, 2021). This is closely related to *weight-based discrimination*, "which is the exclusion or disenfranchisement of individuals due to their weight, and such discrimination is associated with negative psychological outcomes, including depression, poor self-esteem, and body dissatisfaction" (Friedman et al., 2005, as cited in Akoury et al., 2019, p. 93).

Purpose Statements & Contribution to the Field

This capstone will seek to address four purpose statements. The first is to investigate factors contributing to and sustaining selected anti-fat and diet culture literature and media that

are systemically oppressive to women. This is not meant to be an exhaustive review. Building upon this, the second purpose statement is to explore how therapists, as part of healthcare/the medical industrial complex, may cause harm to women in fat bodies and retraumatize clients. In response to this, the third purpose statement is to research trauma-informed healing modalities based in fat liberation. The fourth purpose statement, a culmination of this exploration and analysis, is to create an accessible psychoeducational resource for therapists to use to begin revolutionizing their practice and ethically work with clients.

The recently embraced public discourse that 'mental health is health' acknowledges on a broader level that the field of psychology is part of the medical industrial complex. While modern-day psychology is "based on scientific research and empirical evidence" using critical thinking (Wade et al., 2016, p. 3), the subjective origins of psychology have lingering effects. Psychology became a formal discipline in the nineteenth century when Wilhelm Wundt, who was trained in medicine and philosophy, spearheaded the initiative with the first laboratory in Germany (Wade et al., 2016). One of the erroneous and harmful precursors to theory was phrenology, reading 'bumps' on one's skull, which allowed for subjective condemnation. This was followed by early theories of structuralism, functionalism, and psychoanalysis, the latter of which is considered particularly sexist, overgeneralized, and uninformed of diversity and systemic forces by Freud (Balsam, 2015; Cherry, 2020; Wade et al., 2016). As psychology is rooted in harmful patriarchal and colonial theories (Arthur, 2018), the internalization of anti-fat bias and false health equivalencies is probable in the field. Of critical importance is avoiding the re-traumatization of fat bodies in therapy. There is a risk of both conscious and unconscious harm by the therapist. Sacha Médiné, a Black clinical counsellor, consultant, and educator with expertise in equity, diversity, and inclusion (2021a), explored this in conversation when he

stated, "[counsellors] are on the frontlines of defining for society at large [the] idea of what is healthy and moral" (13:29). Counsellors need to critically examine their personal definitions of 'health', and ethically defer to the client regarding their experience and relationship to their own body and its treatment (Médiné, 2021a). The exploration of trauma-informed and harm reductionist approaches is vital in order to increase safety.

The relationship between therapist and client is highly susceptible to the cogency of power, where the client's voice can easily become muted under the weight of professional expertise (Paré, 2013, p. 16). This recognition, along with the criticism of the field of psychology where "much of mainstream psychotherapy's tenets are deeply colonial and pathologizing and carry the risk of retraumatizing and oppressing clients", create a work environment where counsellors occupy a dominant space (Todd & Wade, 1994, as cited in Arthur, 2018, p. 294). The invisible rendering of contextual cultural factors inflicts harm in a myriad of ways: skewing the understanding of the complex origin of suffering, attributing expressions to the client's nature as opposed to circumstance (Paré, 2013), and inhibiting the essential work and healing which are held as the purpose of counselling. Thus, "dis-investing from single-axis perspectives (i.e., to think of social identities as discrete rather than intertwined) … is essential to challenge insidious manifestations across society" (Grzanka et al., 2019, p. 495).

Due to the significance of the topic and the potential for harm, the results of this research would ideally be shared with all practicing therapists and research-based psychologists. As mentioned above, counsellors are gatekeepers who define health and wellness; they are in a unique position to support healing or to harm vulnerable clients. Psychoeducation is a key piece of the therapeutic process when dealing with anti-fatness and diet culture. Above all, I hope that fat women find healing and community in these words, and that they understand the context of

the pervasive and intentional messaging that harms their mental health. All bodies deserve unbiased healthcare.

Reflexivity and Positionality

I am a white settler student, writing and learning on the traditional, ancestral, stolen lands of the Sḵwx̱wú7mesh (Squamish), Stó:lō and Səl̓ílwətaʔ/Selilwitulh (Tsleil-Waututh), and xʷməθkʷəy̓əm (Musqueam) Nations (Native Land, 2021). It is critical to note my relational location to structures of power, acknowledging how these have influenced my evolving identity and understanding of the material. I am a relatively young, middle-class, small-fat person who is able-bodied, neurotypical, agnostic/spiritual, and a Euro-Canadian-American anglophone. I identify as a queer cisgender woman.

Counselling is inherently political; there is no wellness without justice (Dhebar et al., 2020). This statement is the framework from which I operate. Understanding my location within the structural power of white supremacy and settler colonialism is a continual process of learning and unlearning. To reduce harm and build Allyship within a therapeutic setting I am actively examining my benefit and complicity, while taking steps to address it. I will continue this personal reflection and its application to my practice throughout my life and career. In service to growth and commitment to anti-oppressive and trauma-informed practice, I welcome critique and reflection.

I am a feminist. I am influenced by bell hooks' exploration of what feminism is and the definition of it as a radical, political movement (hooks & Cox, 2014). As feminism is intersectional, my freedom as a woman is contingent upon the freedom of all who are marginalized and oppressed (Arthur, 2018; Crenshaw, n.d.; Hutchison, 2016). Growing up in a capitalist Western society, I was shaped and molded by cis- and hetero-normativity, white

supremacy, patriarchy, classism, racism, ableism, and misogyny. These damaging structures have led to a long path of unlearning, recovery, and healing as it relates to my identity and self-worth. I would be remiss if I did not clearly state that my experience of marginalization is a relative statement, and I acknowledge the relational aspect of oppression and intersectionality. As a small-fat person I experience privilege that is not afforded to other fat people and the experiences cannot and should not be equated. I also occupy locations of power because of my white, cisgender, affluent, and able body. The information and language within this paper reflect a specific period in time, and evolution will inevitably impact norms, social change, and understanding of inclusivity. In addition, I want to acknowledge that this capstone will have areas that lack awareness and that my attempts to encapsulate this issue and honour the resistance will inescapably fall short.

This capstone aims to collect data through both a literature review of current scholarly peer-reviewed sources, and importantly a centering of voices from within the fat community. I am grateful for the unlearning and the education I am experiencing as a result of the labour of marginalized and oppressed women. The honesty in this community of fat activists broke the societal rule of suffering in silence; that if you publicly acknowledge oppression, you and your body are fair game for attack. The social price on the head of this defiance is high (Tovar, 2018). This makes the radical and public call for revolution by these fat women all the more powerful. Thus, while this capstone is not about my personal experiences, these experiences drove my desire to work in the therapeutic space to address body-based oppression and explore healing practices for clients based in liberation.

We cannot disconnect mind and body, as our bodies are the only vessels through which we know and experience this existence. In her book *You Have the Right to Remain Fat* Tovar

(2018) lamented, “my body used to belong to me” (p. 7). Women are told not to trust ourselves–that in existing as we are, we are wrong. Tovar expressed this succinctly saying, “my fat body is frequently attacked on the grounds that I am not beautiful enough to exist because *apparently* that is my job as a woman” (p. 55). In my readings over the years, and in my current research, I discovered a community of fat activists and scholars who inspire me and enable my resistance.

Finally, I want to preface this work by addressing that there exists a cruelty within the fat acceptance movement towards fat people who do engage in diet culture. There is a difference between a fat liberationist politic and a fat person who exists in joy, each a radical feat in this society (Luna, 2021). It is not the expectation that every fat woman has adopted a liberationist politic. The purpose of this paper is to dismantle and attack systemic structures that are in place and that oppress, not to assign blame on any one woman’s agency and actions. Many fat people are attempting to navigate their own internalized anti-fat bias and are doing the best they can with the information they have been forcefully given. With hope for the future liberation of all fat women, I share Tovar’s (2018) poignant summation of the current state:

> The real problem is that our culture is maintained through a vitriolic matrix of sexism, racism, misogyny, transphobia, ableism, healthism, and classism that erodes the physical, spiritual, and mental health of all people; and yet we are told—and we believe—that the problem is that we aren’t trying hard enough. (p. 58)

I intend to recognize and name how hard women have tried, and to engage in work so that mental health will no longer be governable by these oppressive systems and individuals will not be blamed for their systemic trauma.

Key Terms Defined

Anti-fat bias: implicit and explicit negative associations towards fat people and the stigma of fat. This bias disadvantages people in fat bodies and causes harm.

Anti-fatness: "The attitudes, behaviors, and social systems that specifically marginalize, exclude, underserve, and oppress fat bodies", referring "both to individual bigoted beliefs as well as institutional policies designed to marginalize fat people" (Gordon, 2021, para. 13). This term is gaining traction within the fat community as an alternative to *fat phobia*, and prioritizes harm reduction.

Anti-oppressive practice: incorporates the diverse social identities of the client and therapist, acknowledging the clinical relevance of privilege and systemic barriers (Brown, 2019). It is a meta-method of therapy that also extends to therapist advocacy, effecting change in the community and larger society (Brown, 2019). Challenging structural oppression is a political act, therefore engaging in this practice establishes therapy as political (Boggan et al., 2017).

Body-Based Oppression: oppression based solely on one's body, including size, race, gender, ability, et cetera. Put plainly, "body-based oppression is about how the world around us treats our bodies" (Gordon, 2020b, para. 6). Body-based oppression analysis explores the body's relationship to power and privilege (Cantrick et al., 2018). Sonya Renee Taylor (2018) illuminated the fact that body-based oppression is social justice work, naming the body as the site most impacted by social injustice.

Diet Culture: a set of beliefs that values thinness and erroneously equates it to health. Within this doctrine negative self-talk and disordered eating is normalized. There is a preoccupation with one's physical appearance and 'dieting' is promoted as the answer to increasing self-worth.

Diet culture assigns a moral value to food, eating, and body size. Recently, diet culture has co-opted the idea of strength, disguising the use of 'lean' muscles as promotion for thinness.

Fat Acceptance Movement: a social movement that began in the 1960's. Fat acceptance is "believing that bodies come in all shapes and sizes, and that all bodies have equal value" (Walker, 2015, para. 6).

Fat Liberation: a political movement advocating for the rights and dignity of fat people (Walker, 2015). This movement is based in radical activism at the intersection of all fat identities, fighting for freedom from oppression and legal and social justice.

Fat Phobia: an outdated term that refers to the pathological fear of fatness (Gordon, 2021). This term is considered problematic within the fat community as it equates bigotry with being a phobia. Terms to use: anti-fatness or anti-fat bias.

Healthism: the idea that "health [is] a direct outcome of personal choices" (Donaghue and Clemitshaw, 2012, p. 416). Encapsulates the erroneous and harmful idea that health status is a changeable personal characteristic completely in one's control.

Intersectionality: is defined as "multiple social systems intersect[ing] to produce and sustain complex inequalities", noting that it "is best conceptualized as a lens through which research and social action can take seriously the ways in which individuals are situated within complex social systems" (Grzanka et al., 2019, p. 493). The term was created by race and gender equality specialist, civil rights activist, leading scholar of critical race theory, and lawyer Kimberlé Crenshaw in 1989 (Crenshaw, n.d.).

Misogynoir: is anti-black racialized misogyny experienced by black women (Bailey, n.d.). This term was created by queer Black feminist Moya Bailey in 2010.

Misogyny: enforces ingrained prejudice against women, and includes contempt for and the control and punishment of women who challenge male dominance (Manne, 2018). Misogyny is hostile and operates with and within other oppressive structures.

Patriarchy: is a "social system built on concepts of domination, separation, and control. It is a system that privileges masculinity and men over femininity and women, and keeps men in positions of power, domination, and control over women, girls, and gender-diverse people" (Yasmin Hajian, as cited in Médiné, 2021b, para. 1).

Sexism: is a prejudiced ideology discriminating against women based on sex and to support patriarchal social inequality (Manne, 2018).

Sizeism: is defined as "discrimination or prejudice directed against people because of their size and especially because of their weight" (Gordon, 2021, para. 11). The term does not specifically state the extent of oppression faced by fat people.

Women: a term inclusive of trans and cis women and other people oppressed by misogyny (Ricketts, 2021). While gender is expansive, this capstone explores the specific gendered aspects of anti-fatness as experienced by women. 2-spirit, trans men, non-binary and genderqueer people are all impacted by misogyny and anti-fat bias, and the nuance of these experiences are outside of the scope of this capstone, in addition to there being a lack of research. I chose to not use the term *womxn* (or any other spelling) because while this was originally intended to cut out 'men' from the word and be more inclusive, it evolved to be a flawed 'catch all'. *Womxn* others trans women and invalidates non-binary people (López, 2021). Calling non-binary people *womxn* needlessly genders them and erases unique impacts of women's issues (López, 2021). I chose to use this term at this moment in time, and acknowledge language evolves as we learn more.

Analysis: Conceptual Framework

I am using intersectional feminist theory and a participatory-social justice framework to analyze existing literature and research. Intersectionality is defined as "multiple social systems intersect[ing] to produce and sustain complex inequalities", noting that it "is best conceptualized as a lens through which research and social action can take seriously the ways in which individuals are situated within complex social systems" (Grzanka et al., 2019, p. 493). The term was created by race and gender equality specialist, civil rights activist, leading scholar of critical race theory, and lawyer Kimberlé Crenshaw (Crenshaw, n.d.). Feminist theory explores the inequality of gender relations and conceptualizes women's experiences of oppression, based in feminism: "a belief in the social, political, and economic equality of the sexes" (Evans et al., 2014, p. 2). Intersectional feminist theory is the framework through which I approach therapeutic practice, radically supporting human rights and equality in a way that includes all people. Equality and activism demand that women have control over their own bodies (hooks & Cox, 2014), and this extends from laws and politics to the degradation of women's worth through impossible aesthetic standards and the violent enforcement of anti-fatness. A participatory-social justice framework "is a lens for looking at a problem recognizing the non-neutrality of knowledge, the pervasive influence of human interests, and issues such as power and social relationships" (Creswell & Creswell, 2018, p. 72). I will use this framework when examining the variables and systems in place supporting anti-fatness and to identify mental health themes within the readings.

Complementing these theories is an anti-oppressive and trauma-informed practice through which I will analyze modalities and existing theories and research. Anti-oppressive practice incorporates the diverse social identities of the client and therapist, acknowledging the

clinical relevance of privilege and systemic barriers (Brown, 2019). Therapy is required to become political through engaging in this practice, as challenging structural oppression is a political act (Boggan et al., 2017). Trauma-informed care is believed to support health equity (Han et al., 2021). Health inequity is maintained by chronic adversity such as discrimination, thus trauma-informed practice is crucial to work within fat liberation. Additionally, I will use fat liberationist politics as a lens through which to view progress and gaps in knowledge and action.

Relevant Background

Fat, black, queer women with disabilities are at the heart of Fat Liberation. People who occupy these intersectional identities are the most marginalized bodies experiencing oppression. It is crucial to note that the communities publicly driving Fat Liberation in the 1970's were white queer women, decentering the racialized voices of the people most at risk. This was clearly expressed by Luna (2021), a fat queer Tejanx activist, stating that "non-Black & non-Indigenous fat activists need to center Black liberation & Indigenous sovereignty in our activism" (para. 1). These populations were not adequately represented in the early waves of fat feminism, however racialized intersectionality is finally becoming more prominent in current literature.

The radical Fat Liberationist movement has changed over time into two different mainstream movements: health at every size (HAES) and body positivity (Bopo). HAES grew out of the Fat Liberationist work by the Fat Underground and Fat Lip Theatre (Fishman, 1998; McHugh & Chrisler, 2019; Simon, 2019). Bacon (2019), a prominent researcher in the field, summarizes the HAES movement's key points, including: criticizing the body mass index (BMI), denouncing obesity as a disease, and promoting an inclusive society with respectful public health initiatives rooted in self-care. HAES is currently presented by many researchers as a framework for healing. Body positivity, alternatively, is a diluted movement without the

revolutionary and radical power of liberation (Simon, 2019). Originally meant to be one facet of fat acceptance, Bopo does not encourage women towards power and freedom, and is ultimately pushing for assimilation into the current system (Dionne, 2017). The movement also centers thin, white, cis-het women who are archetypically attractive, erasing the most marginalized populations and racialized bodies (Dionne, 2017; Simon, 2019). This muted ideology has, and continues to, neutralize women's resistance (Ramati-Ziber et al., 2020). Tovar (2018) critically states the difference between radical liberation and the body positivity movement, in that "acceptance was not a desired outcome because absorption into the racist, patriarchal, and fatphobic culture that has systematically dehumanized you isn't exactly a win" (p. 92).

Ideal Norms, Hierarchies, and Control

Through the targeted efforts of patriarchal white supremacist values "female corporeity in Western Culture" has been reduced to an 'ideal' model (Ponterotto, 2016, p. 133). This norm creates a "deficit paradigm" where a body that deviates is "socially stigmatized as unacceptable, unworthy and needy of correction" (Ponterotto, 2016, p. 139). Ponterotto pointed to this societally enforced homogeneity as the stripping of female agency: women must conform or be marginalized. Thus, ostracization due to fat phobia instills the fear of being an outcast in people. To be 'different' is to be a social outsider–a situation that has destructive effects on mental health, relationships, and safety (Estefan & Roughley, 2018). Tovar (2018) supported this, declaring that "internalized inferiority is part of sexism, and diet culture feeds on that sense of inferiority" (p. 45).

The feminist movement—even with its substantial and liberating social, legal, and political gains—was unable to break this weaponized ideal norm (Calvo-Pascual, 2017; Ponterotto, 2016). When women gain power, their bodies are seized (Wolf, 1991). In times of

progress women are purposely undermined, resulting in an increase in eating disorders, cosmetic surgery, pornography consumption, and negative body image and self-esteem (Calvo-Pascual, 2017; Ponterotto, 2016). Capitalism continues to enforce this marginalization through racism and sexism, driving consumerism as the answer (Ponterotto, 2016).

Wolf (1990, as cited in Ramati-Ziber et al., 2020) explained that "the beauty myth [has] always actually [been] prescribing behaviour and not appearance" (p .14). The pursuance of the ideal female standard strengthens men's power and the 'gender' divide; these practises have varied between cultures, exemplified by Chinese women displacing bones with foot-binding, and Western women displacing their organs with corsets (Ramati-Ziber et al., 2020). Throughout colonial history, "morality [has been] attached to physicality" (Felkins, 2019, p. 182). The connection between size and moral judgement allows for justification of social hierarchy and oppression based on class and race (Felkins, 2019; Strings, 2019). Gonzales (2019) spoke to this hierarchy, stating that the pursuit of a thin body, for Black women especially, represented access to higher status and privilege. The adherence to this ideal in Western society is based on submission, which Tovar (2018) noted as being eroticized and informed by white supremacy.

Diet Culture & The Medical Industrial Complex

Incomplete and false medical 'data' perpetuated by the medical industry espouses a causal relationship between weight and health issues such as chronic illness and even death (Felkins, 2019; Fishman, 1998). Fat acceptance and liberationist groups clearly differentiate between correlation and causation, revealing that stress due to oppression and the invalidation of a group of people (i.e. any marginalized population) are the true cause of illness, chronic disease, and negative symptoms blamed on fatness (Dean, 1979). In fact, one seminal group called the Fat Underground stated that dieting is the main "cause of early deaths in fat people" (Dean,

1979, 11:13); fat women starve and suffer from low self-esteem based on the 'good fatty' lie, yet long-term medical studies show that "99 percent of people who lose weight gain it back, and 90 percent of people gain back more than they lost" (Tovar, 2018, p. 56). Pausé (2019) and more studies found that 95% of people did not maintain permanent or meaningful weight loss. These studies also showed that 'fat' and 'thin' people eat approximately the same amount, which invalidates the cultural view of fatness as being immoral, excessive, and societally punishable.

Fat acceptance groups claimed that "weight loss is genocide" perpetuated by the diet industry, a major economic force (Fishman, 1998, para. 2; Dean, 1979). These women understood liberation to be the abolition of diet culture—a product of misogyny and patriarchy—as they experienced just "how violent and absurd and unnecessary diet culture is" (Tovar, 2018, p. 24). Untruths have cleared the path for culturally-endorsed bigotry disguised as 'concern', and the vicious policing of fat bodies (Felkins, 2019; Bacon & Severson, 2019). Further, "there are psychological consequences to dieting … Research on dieting and weight loss demonstrated a relationship between dieting and increases in depression, anxiety, and social withdrawal" (Wooley & Garner, 1994, as cited in McHugh & Kasardo, 2012, p. 618).

Psychotherapeutic Relevance

Psychology has a deeply harmful history of pathologizing bodies that vary from the 'norm' created by colonial, white supremacist, patriarchal, misogynistic, classist, and ableist culture (Todd & Wade, 1994, as cited in Arthur, 2018). Due to the violence enacted by the health care profession there is a substantial amount of healing and change that needs to occur. When speaking about LGBTQ+ peoples' distrust of this system, Sinclair Sexsmith (as cited by Cahill, 2017) said, "the message is clear: They do not understand my body ... So why would I trust them to help me with my health and wellness?" (para. 7). Why would fat women trust that they will

not be retraumatized in session when psychological theories are rooted in these larger oppressive structures? Cahill (2017) reiterated this serious issue, as people who have experienced incompetent care may be less likely to seek out health and wellness care in the future due to the risk of discrimination and further suffering.

Objectification Theory "holds that women react to societal objectification by taking on an observer's perspective of their own bodies to determine self-worth" (Fredrickson & Roberts, 1997, as cited by Ponterotto, 2016, p. 139). Thus, women are conditioned into believing they want to be thin and hypersexualized, and that their value lies in the consumption of their physical appearance (van den Brink et al., 2018). This can be extremely detrimental to development, as evaluating oneself based on appearance leads to an overall self-consciousness that can extend to self-hatred, shame, and deep feelings of inferiority (Fredrickson & Roberts, 1997, as cited in van den Brink et al., 2018). Ponterotto (2016) also suggested that this then becomes critical to the psychosocial health of women to conform, to be desired, feminine, and loved, and to avoid being judged and ostracized (Ramati-Ziber et al., 2020). Further, the racism and misogyny that drive fat phobia and anti-fat rhetoric heightens the risk for low self-esteem, depression, and stigmatization (Felkins, 2019).

The internal work of fat women begins with acceptance. However, the cost of this freedom is the release of hope, which is perhaps the most difficult act. The hope involves the fantasy that the body will be different, accepted by society, and no longer oppressed. This is a cultural and moral failure, not an individual one (Bacon & Severson, 2019). Failing to check anti-fat bias leads to the acting out of bigoted and discriminative ideologies, further harming a vulnerable population. Marilyn Wann (as cited by Fat Mystic, 2020), a fat activist and author of

Fat!So? states: “the only thing that anyone can diagnose with any certainty, by looking at a fat person, is their own level of stereotype and prejudice toward fat people” (para. 1).

It is vital that counsellors critically assess theories, treatment modalities, and the DSM-5 or risk pathologizing and harming clients. Anti-fat bias is a “persistent and widespread barrier to body liberation that psychotherapists are ethically bound to do something about … We are not truly seeing our clients if we do not seek to understand the suffering that accompanies body-based oppression” (Kinavey & Cool, 2019, p. 116). For a therapeutic space to be safe for all bodies, the data supports that counsellors provide a client-centered, anti-oppressive approach based in feminist theory and fat liberationist politics to ensure equal care and treatment.

Outline of Capstone Chapters

The purpose of this chapter is to highlight how anti-fatness has been created and perpetuated by systemic forces of oppression and to initiate the research showing the detrimental effects of this on women’s mental health. In addition, this chapter introduces how the field of psychology, as part of medical care, has the potential to do harm and has fallen short in treating and supporting fat women. Chapter two will be comprised of a literature review encompassing recent and relevant scholarly peer-reviewed sources. As mentioned in a previous section, of critical importance to this capstone will be the centering of voices from within the fat community. Thus, research will also be collected from a variety of past and contemporary voices in the fat liberation movement. The analysis will involve an exploration of factors contributing to and sustaining oppressive anti-fat/diet culture literature and media, the language of body trauma, harm in healthcare, and current offerings in the field of trauma-informed healing modalities for fat bodies. Chapter three will be a culmination of the research and analysis in this capstone: an

accessible psychoeducational resource for therapists to begin revolutionizing their practice and ethically work with clients from a fat liberationist politic.

Chapter 2: Literature Review

Factors Contributing to & Sustaining Oppressive Anti-Fat/Diet Culture Literature and Media

Overview: Systemic Racism of Fat Phobia

Racist, colonial scientific literature is recognized as the catalyst of modern-day hatred of fat bodies (Luna, 2021). As spoken to in chapter one, fatness has always existed, and bodies were not inherently pathologized or assigned status. Strings (2019) argued in her book, *Fearing the Black Body: Racial Origins of Fat Phobia*, that:

> Two critical historical developments contributed to a fetish for svelteness and a phobia about fatness: the rise of the transatlantic slave trade and the spread of Protestantism. Racial scientific rhetoric about slavery linked fatness to 'greedy' Africans. And religious discourse suggested that overeating was ungodly. (p. 6)

Within the connection of Blackness and fatness during European colonization, a negative narrative was thus created through racism, class, and bias (Strings, 2019). White supremacy dictated a social hierarchy through differentiation, which—as social theorist Pierre Bourdieu (2011) stated—gave accepted meaning to the capital held by the elite. Through demeaning Black women and controlling white women, this narrative served to maintain the power of white men (Strings, 2019).

Fatness "disrupts the cultural obsession that women need to be clearly and visibly distinguishable from men," putting pressure on the strict rules that misogyny and patriarchy have levied against women (Tovar, 2018, p. 82). Murray (2008) expanded on this, conveying that a moral anxiety exists within Western culture based on binary gender identities, and extending to female sexuality and embodiment rules. This restricted view of femininity means to be small

both physically and in one's expression of self. This feminine ideal is impossible to separate from racism; patriarchy and misogynoir demonize Black bodies, attributing hypersexual deviance, laziness, emasculation, and gluttony to Black women (Gonzales, 2019; Strings, 2019). Prejudiced views claimed whiteness as civilized, while terrorizing and fetishizing Black women (Weber, 2017). Thus, whiteness and thinness became the moral standard for women. Strejcek and Zhong (2014) further commented on the narrative of morality as being in regular opposition with the body; that the body's desires and appetites are not a reflection of the 'correct' conduct and values modern society espouses. Additionally, moral panics are associated with fast social change paired with exaggerated fear tactics, and stigmatized groups become the socially condemned (Campos et al., 2006). Fat women of colour became the targets of derision. Author and gender studies professor, Shannon Weber (2017), denounced "this use of distorted science to confirm pre-existing biases [as this] is what helped propel the popularity of eugenics well into the 20th century, resulting in mass atrocities" (para. 6). Weber further connects white supremacist ideologies with devaluing fat bodies, as controlling women's bodies is decreed with an end goal of heterosexual, white reproduction.

Crucial to the understanding of the scope of oppression, fat Black women are further at risk from the enforcement of classism through misogynoir and food deserts (Felkins, 2019). Due to the focus on demeaning Black women's bodies, combined with social inequities beginning in enslavement, anti-black misogyny and anti-fatness became the cultural narrative (Strings, 2020). *Food deserts* exist in both urban and rural communities and are "areas where there is little or no access to healthy and affordable food" (Treuhaft & Karpyn, 2010, p. 7). Evidence proves that food deserts disproportionately affect BIPOC (specifically Black) and low-income communities and are a social justice issue perpetrating harm to local economic development through racial

inequality (Treuhaft & Karpyn, 2010). Thus, anti-black racism and misogynoir led to the socially accepted bias of anti-fatness.

Violence and Marginalization

Stigma can be defined as occurring "when persons experience a sense of ontological inferiority and fear of poor treatment" (Pausé, 2012, p. 47), and by the World Health Organization (2001) as "a mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society" (p. 16). Stigma, as proposed by Erving Goffman (1963), can be characterized into three types: abominations of the body, blemishes of individual character, and group stigma of race, nation, and religion. "The stigma of a fat body falls into [the first] two categories … as body size is perceived to be under an individual's control and fatness an evidence of sloth and permissive character" (Pausé, 2012, p. 44). Goffman then identified three ways for a stigmatized person to manage their identity—through assumed behaviours and attitudes—for survival; the techniques include passing, covering, and withdrawing. To blend into the dominant group is known as passing. Covering is expressed through assimilative techniques to reduce tension (i.e. openly repentant/shameful), and withdrawal is a removal of self from stigmatized society to safety (Pausé, 2012). In line with societal narratives driving fat stigma and violence, "fat people engage in covering when they are willing to endure discrimination, because it is what they believe they deserve as fat people" (Pausé, 2012, p. 48). Bias and discrimination are the results of fat stigma's devaluation of people, with anti-fat attitudes promoting negative beliefs including laziness, unattractiveness, and being out of control (Greenberg et al., 2003). Bias against fat people reaches past interpersonal relationships, including discrimination in medical treatment, employment, and education (Tomiyama & Mann, 2013). Fikkan and Rothblum (2012) are

among numerous studies over decades that have verified that the punishments of fatness, especially for women, extend to employment, income, education, health care, media portrayals, and well-being (see also Flint et al., 2016; Jovančević & Jović, 2021).

Another form of violence is the experience of being reduced to one trait: fatness becomes the sole lens through which a person is viewed. Specifically, the "overdetermination of identity by the body was drawn on to express [women's] frustration and hurt at the persistent misrecognition brought on by their bodies" (Donaghue & Clemitshaw, 2012, p. 423). Even in close intimate relationships, fat women experienced their value and accomplishments being diminished and eclipsed by their body size. Assigning morality to a person solely through their body is allowing bodily input to drive interrelations within society, disparaging the other and propagating discrimination (Greenberg et al., 2003). Additionally, this contributes to what is referred to as the hyper(in)visibility of fatness, which builds upon Casper and Moore's (2009, as cited in Gailey, 2014) *ocular ethic* analyzing concealed bodies (Gailey, 2014; see also McDermid, 2022). Gailey (2014) wrote:

> Fat presents an *apparent* paradox because it is visible and dissected publicly; in this respect, it is *hypervisible*. Fat is also marginalized and erased; in this respect, it is *hyperinvisible*… To be hyper(in)visible means that a person is sometimes paid exceptional attention and is sometimes exceptionally overlooked, and it can happen simultaneously. Fat women are hyperinvisible in that their needs, desires, and lives are grossly overlooked, yet at the same time they are hypervisible because their bodies literally take up more physical space than other bodies and they are the target of a disproportionate amount of critical judgment. (p. 7-8)

Hyper(in)visibility is violent in its erasure of humanity and in its ensuing bias and prejudice.

Resistance has always existed alongside oppression. Campbell and Meynell (2010) expressed that "the human body is an agent, inevitably transforming through its actions both the world and itself" (p. 1). People do not have the luxury of ignoring the body when they are oppressed because of their body; their agency in the world is denied, as there is no 'passing' as thin (Gonzales, 2019). Saguy and Ward (2011) built on this further, as many fat women do try to avoid marginalization through passing as 'on-the-way-to' thin. By letting go of diet culture and through acceptance of self, Saguy and Ward distinguished both the difficulty and the beauty in the radical resistance of "coming out as fat" (p. 54). This difficulty was echoed by Donaghue and Clemitshaw's (2012) study, which acknowledged both the concrete benefits and ease of life that are removed when thinness is relinquished. Cat Pausé, a Fat Studies scholar, also spoke to 'coming out' as fat in a 2012 autoethnography (a method that weaves theory, literature, and personal experience). Pausé (2012) agreed on the risks present in a fatphobic culture, rejecting the unambiguous identity shift, and "propose[d] that embracing a fat identity does not preclude the occasional questioning, dissonance, or feeling of uncertainty" due to these risks (p. 43).

The liberation within the concept of *Fat Pride* is deliberated amongst scholars and activists due to the violence experienced by people in fat bodies and the privilege of thinness. For example, in Murray's 2008 book, *The 'Fat' Female Body*, she named the individual assertion of fat pride as unrealistic due to the cultural demonization of fat. Murray stated that claiming fat pride reproduces "the logic of confession, which, as Foucault points out, *produces* individuals (as aberrant for the most part) rather than *liberating* them" (p. 107). Donaghue and Clemitshaw (2012) explored this further, noting that fat people cannot simply 'rise above' within hegemonic construction without real consequence. This continued violence is also often internalized by women, who "with long histories of relating to their own bodies with disgust and

disappointment… engag[e] in punishing and usually futile regimes to discipline their bodies into an 'acceptable form'" (Donaghue & Clemitshaw, 2012, p. 422).

Control and Neoliberal Ideologies

Structural violence has also been deployed through neoliberal ideology, "plac[ing] the burden of fat phobia on populations already burdened with other forms of marginalization" (Felkins, 2019, p. 183). Neoliberal ideology is based in free-market capitalism and unregulated competition. Research shows that neoliberal policies solely benefit the class in power and contribute to extreme social inequality (Navarro, 2007). "Despite the significant sociocultural and economic conditions that contribute to [fatness]," the stigma and blame lies solely on the individual (Tomiyama & Mann, 2013, p. 5). Fat women are positioned as inferior, morally and physically, thus society rewards women who comply, and simultaneously rewards fear and bigotry (Dean, 1979; Ramati- Ziber et al., 2020). This focus on individual responsibility allows for willful ignorance of structural forces and promotes collective hate and abuse. Saguy and Gruys' (2010) research supported this as they identified the typical storyline of personal responsibility in media portrayals of fatness. This research originated from a comparative case study of news reporting from 1995 to 2005; people who were 'overweight' were blamed for making "bad individual choices" and they were stereotyped as "out of control and lazy" (Saguy & Gruys, 2010, p. 231).

The continued equation of fat and health has permeated the consciousness of Western societies (Bacon & Severson, 2019). Healthism contributes to the aesthetic discourses and neoliberal ideologies that cause harm (Donaghue & Clemitshaw, 2012). *Healthism*, according to Donaghue and Clemitshaw (2012), is encapsulated by the idea that "health [is] a direct outcome of personal choices" (p. 416). Thus, health status is seen as a changeable personal characteristic

and fatness becomes the gauge for a person's ability to manage themselves and their life, deeming a person morally responsible or irresponsible. Fat is then symbolically assessed as a measure of the moral and social worth of a human (Saguy & Gruys, 2010). Healthism introduced a dangerous precedent for people with fat bodies to be seen as "(allegedly) displaying disregard for their own health thus becom[ing] 'legitimate' targets of social sanction and 'caring' intervention" (Rice, 2007; Throsby 2007, 2008; Tischner & Malson, 2008, 2010, as cited in Donaghue & Clemitshaw, 2012, p. 416). In practice, these "interventions" are regularly experienced as harm through microaggressions, shaming, and enacted bigotry.

Tiggemann (1994) explored the normative dissatisfaction in Western culture for how women feel about their bodies. Through path analysis of 332 Australian undergraduate students (self-identified as 202 women and 130 men), women's self-esteem was found to be negatively impacted by their subjective perception of being 'overweight,' in line with societal pressures and self-concept theory (Tiggemann, 1994). Later research confirmed that this is understood to mean that women are failing to use critical thinking when engaging with media portraying the thin ideal (Donaghue & Clemitshaw, 2012). Various studies have found this neoliberal interpretation of self-responsibility to be untrue. Vares et al.'s (2011) study in New Zealand of 71 preteen girls who were media literate and savvy found that they still expressed feeling "bad" and "sad" after viewing thin, ideal images of women. This three-year empirical study opened up a nuanced dialogue between agency and influence, challenging the binary rhetoric of sufferer versus critical engagement (Vares et al., 2011). An Australian study of high school girls by Carey et al. (2011) had similar findings: despite body image workshops within school curriculum, the participants still experienced immense pressure to be thin and felt that their challenging lived experiences were unacknowledged. It is necessary to note that these studies used the binary categorization of

'girls' and may exclude youth who are impacted by misogyny, including those who identify outside of the binary, affecting results and data collected. "The privileges attached to thinness are very real and reinforce the importance of understanding preoccupation with weight as a thoroughly social issue" (Donaghue & Clemitshaw, 2012, p. 416). Major and O'Brien (2005) also remarked on the contextual relationship of stigma as a means of social control in their article, *The Social Psychology of Stigma*. Fat bodies are controlled through community reinforcement: "stigma is relationship- and context-specific; it does not reside in the person but in a social context" (Major & O'Brien, 2005, p. 395).

A study by Donaghue and Clemitshaw (2012) analyzed 499 comments from the popular fat acceptance blog, *Shapely Prose,* using a feminist poststructuralist view. Four main themes were found: diets do not work and this pursuit of thinness was experienced as self-limiting and miserable; thinness does not equal happiness; real loss due to the reality of thin privilege; and misrecognition by others. All of these themes interact to support the experience of "the dilemmatic nature of fat acceptance": deep distress is espoused by those committed intellectually to fat acceptance, yet who experience "the strong draw of the desire to be thin" (Donaghue & Clemitshaw, 2012, p. 422). Fat acceptance is thus seen as a continual resistance of the all-consuming culturally sanctioned ideal, rather than an achieved state. Gergen's (1994, as cited by Donaghue & Clemitshaw, 2012) location of identity as relational further impacts the experience of fatness: one's view of self needs to be externally reflected and endorsed. Donaghue and Clemitshaw applied relational identity to neoliberal politics and identified the necessity of fat acceptance to be a more widely engaged political project addressing entrenched oppressive ideology.

The Language of Trauma

Terminology & Labels

Terminology leads to and reinforces bias while impacting health. Meadows and Daníelsdóttir (2016) commented on "what's in a word" when they explored "terminology used in weight stigma research and professional practice to describe higher-weight bodies and to identify best practice—how to engage in the conversation without being part of the problem" (p. 1). They found that there may not be one answer, depending on the person(s) being interacted with within the target group: individuals should be regarded as the expert in their identity politics. *Labeling* has been identified as inherently creating a category of 'us' and 'them,' thus participating in othering (Meadows & Daníelsdóttir, 2016). This begs the question, is it possible to not use classification? Is it possible to eliminate difference? Meadows and Daníelsdóttir noted that "it is undoubtedly useful to define a group for research purposes, for example, so that barriers and discrimination they face can be quantified and addressed" (p. 1). Within this, there is acknowledgement that distinctions can lead to differential treatment. Further, this introduces an investigation into who occupies power, therefore possessing the ability to label.

One 'solution' presented by numerous scholars is to engage in person-first language—originated within Disability Justice—that places "person with" in front of the following descriptor, e.g., "person with obesity" (Kyle & Puhl, 2014; Wittert et al., 2015). Kyle and Puhl (2014) noted how weight bias is enforced by using stigmatizing language, and that there are proven attitude and behavioural shifts with person-first language. Bajaj and Stanford (2021) also spoke to the importance of this type of language in supporting the respect and dignity of fat persons. Additionally, the American Psychological Association requires authors to use person-first language in their writings and publications (American Psychological Association, 2020). It

is crucial to note the hypocrisy and harm, in that although these authors are presenting research to reduce bias, they are also using the stigmatizing term ‘obese’ that will be spoken to in the next section. Person-first language is criticized by the fat community and other scholars (NAAFA, 2015). Meadows and Daníelsdóttir (2016) suggested that this shift is at best superficial, and at worst implying an affliction that needs fixing/removing, evoking Goffman (1963) in their analysis of defect as stigma. This point is supported by research showing that anti-fat attitudes remain regardless of person-first language, especially amongst specialists and health practitioners (Flint and Reale, 2014; Garcia et al., 2016; Puhl et al., 2014; Tomiyama et al., 2015, as cited in Meadows & Daníelsdóttir, 2016). Fundamental to this review are the voices within the fat community, and representative grassroots organizations vehemently object to person-first language (NAAFA, 2015). These human rights organizations include the National Association to Advance Fat Acceptance (NAAFA), the Association for Size Diversity and Health, the Big Gay Men’s Organization, the It Gets Fatter Project, and the International Size Acceptance Association (NAAFA, 2015). They noted that fat people were not consulted and that person-first language for a trait or characteristic—such as size—was devised to support the medical industrial complex’s designation of fat as a disease (NAAFA, 2015).

A study by Flint and Snook (2014) found that there is little deterrence, legally or socially, in discrimination towards fat people, which negatively impacts well-being. Further, Jovančević and Jović (2021) analyzed multiple studies from the 1990’s and found that it was not only socially acceptable, but it was also ‘desirable’ to express prejudice towards fat people. Socially acceptable prejudice is tied to language: a study by Wittenbrink et al. (1997, as cited in Jovančević & Jović, 2021) showed that “people with different prejudice levels differ in the speed with which they recognize positive and negative words pertaining to stereotyped groups” (p. 5).

This connection of language and prejudice is supported by research on social influence collected over a century: attitudes of others greatly sway human beings (Latané, 1981; Ravary et al., 2019). “People generally learn normative information from the behaviour of other people: what they do and what they say” (Hogg, 2010, p. 1176). Ultimately, as Meadows and Daníelsdóttir (2016) stated:

> Labels all reflect certain culturally constructed values. It behooves us to ask ourselves whether the words we use do indeed affirm the respect and human dignity of the target group, whether they place the group as equal to other social groups, and whether they promote or hamper the wellbeing and empowerment of that group. If not, we will only perpetuate the stigma we are claiming to abolish. (p. 3)

Thus, terminology and labels play a key role in a person’s well-being, their perception of safety, and in existing free from bias.

Obesity, Fat, & Fat Phobia

The term *obesity* has been referred to as both pathologizing and oppressive. While this has been lamented by fat liberationists and activists from within the fat community for years, scholarly research and healthcare is still plagued with the term. *Obese* originates from the Latin word *obesus*, which means ‘having eaten oneself fat’; thus, the root of the term is oppressive in its neoliberal individual blame and othering (Gordon, 2020). “Obesity in the sociopolitical sense became institutionalized fairly rapidly in universities and governments in the late 20th century” (Carter & Walls, 2013, para. 10). During this institutionalization, the scientific and sociopolitical meaning became enmeshed. Fat bodies thus became medicalized and anti-fatness was expressed through the term *obesity*, which masquerades as a medical term indicating health.

In a 2016 Australian study by Thomas et al. (2008), 76 fat adults who were seeking weight-related treatment were surveyed. They found that half of the participants had been "humiliated or had derogatory comments made" by health professionals, and that although medical institutions claim the term *obesity* is neutral, 80% of people actively hated the term and preferred *fat* or even *overweight* (Thomas et al., 2008, p. 327). Contributing to this number is the fact that the term is linked with societal disapproval (Thomas et al., 2008). Carter and Walls (2013) commented on this prejudice, which was buoyed by the social and political negatives that *obesity* continues to be connected with. Carter and Walls appealed for the term *obesity* to be removed from names of medical and advocacy organizations alike. Meadows and Daníelsdóttir (2016) further "suggest that best practice in research, publishing, and healthcare would be to use neutral terms, with "weight" and "higher weight" likely to be suitable in the majority of situations" (p. 3). NAAFA (2015) also uses the more neutral term *higher-weight people* in place of other harmful descriptors in its writings and advocacy. It is of importance to note that while *higher-weight* and *overweight* may sound similar, they are differentiated by researchers and the fat community. 'Overweight' has a negative connotation and implies an established norm, which is not scientifically reputable, and further medicalizes body diversity (McHugh & Chrisler, 2019).

The word *fat* has been publicly and unanimously considered pejorative (Brochu & Esses, 2011; Mohammed, 2020; Trainer et al., 2015). Saguy and Ward (2011) spoke about the reclamation of *fat* as a descriptor that is both neutral and normalizing by people in fat bodies. Linguistic reclamation has been used in other marginalized groups' movements, namely the LGBTQIA2S+ community reclaiming pejorative terms intended to shame (Brontsema, 2004). Targeted groups reclaiming derogatory epithets have both supporters and opposers depending on

their experience of what it means to separate the term from its pejoration (Brontsema, 2004). In 1993, Sedgwick et al. wrote about being 'out as fat', saying "it is a way of staking one's claim to insist on, and participate actively in, a renegotiation of the representational contract between one's body and one's world" (p. 230). Part of this renegotiation is not accepting anti-fat language and behaviour from people that one engages with. "Thus, identifying as "fat" becomes an act of empowerment and a marker of self-respect and unity" (Meadows & Daníelsdóttir, 2016, p. 2; see also Saguy & Ward, 2011).

Fat phobia is defined as "a pathological fear of fatness" (Robinson et al., 1993, p. 467). The fat community views this as an outdated term that equates bigotry with being a valid phobia, which ultimately stigmatizes mental illnesses (Gordon, 2021). Gordon (2021) noted how "*Fat phobia* is an appealing term because it's self-explanatory, easily defined as a fear of fatness and fat people. It fits the template of other *phobia*-suffixed terms used to describe oppressive attitudes: *homophobia, transphobia, xenophobia"* (para. 2). The language of *phobia* itself is oppressive in its inaccuracy and inadequacy (Monroe, 2016). This language contributes to erasure, trivialization, and dehumanization, and ultimately harms the oppressed in their pursuit of liberation (Monroe, 2016). *Phobia* "centers the oppressor … [it] becomes about their fear instead of our struggle" (Monroe, 2016, Section 3, para. 10). As language has a sociopsychological effect, using a term such as *fat phobia* harms fat people by impacting self-worth, political power, and interpersonal relations (Gordon, 2021; Monroe, 2016). Another term that is used alongside *fat phobia* is *sizeism*. *Sizeism* is defined as "discrimination or prejudice directed against people because of their size and especially because of their weight" (Gordon, 2021, para. 11). *Sizeism* does not, however, specifically state the extent of oppression faced by fat people. The term that is gaining traction within the fat community as an alternative to *fat phobia*, which prioritizes

harm reduction, is *anti-fatness*. Anti-fatness is defined as "the attitudes, behaviors, and social systems that specifically marginalize, exclude, underserve, and oppress fat bodies", referring "both to individual bigoted beliefs as well as institutional policies designed to marginalize fat people" (Gordon, 2021, para. 13).

Harm & Experiences in Healthcare

Medical Industrial Complex

Western medical opinion and discourse about body weight were far from uniform until a shift in the early 1900's. Prior to this time, "body weight was allowed to hold multiple symbolic positions, with thinness and fatness understood as both positive and negative" (Hutson, 2017, p. 284). Hutson's (2017) findings resulted from analysis of medical documents and journals from the nineteenth century, observing how fat shifted from valued to stigmatized. Fatness was then regarded as signifying health and wealth, as well as fashionable fads (Stearns, 2002). While the shift was shaped by a combination of medicine, fashion, 'efficiency' science, and politics (Hutson, 2017), bias existed first and then medicine began to reflect this partiality. The move began medically with a specific study published by Dr. Brandreth Symonds for a life insurance company focused on weight and mortality (Czerniawski, 2010; Hutson, 2017).

The Body Mass Index (BMI) scale was originally created in the 1830's by Adolphe Quetelet, a Belgian mathematician, statistician, and sociologist who was searching for the 'ideal' average man (Blackburn & Jacobs Jr, 2014). Quetelet himself acknowledged that BMI was created to measure populations, not individual fat and health (Blackburn & Jacobs Jr, 2014; Gordon, 2019). This controversial work is linked with the psychological and social theories of anthropometry, phrenology, and eugenics that espoused systematic prejudice and are inherently racist (Gordon, 2019; Turda, 2013, Wade et al., 2016). BMI was eventually popularized from the

initial concept of ‘excess’ weight that life insurance companies claimed, creating a baseline of ‘normality,’ inherently categorizing certain body weights as abnormal. In 1998 the US National Heart, Lung, and Blood Institute “revised the BMI guidelines and reduced the upper limit of the Normal category to 24.9 [from 27.3]” (Hutson, 2019, p. 111; see also Kuczmarski & Flegal, 2000). This reclassification, along with sensational media headlines covering the ‘obesity epidemic,’ lead to the problematic symbiotic relationship between cultural canons and medical ideologies (Boero, 2012). BMI is continually contested as an indication of health, and is proven to have extreme limitations, yet remains widely used as a leading diagnostic tool (Hutson, 2019).

Felkins (2019) summed up the harm done in “medico-scientific literature’s” classification of fat people and ‘obesogenic’ areas as “legitimiz[ing] the state-sanctioned labeling of these communities as deviant–through race, class, and size” (p. 183). The stigma associated with body weight has been strengthened by its medicalization (Hutson., 2019). Conceptually, *medicalization* “describes how non-medical phenomena become understood as medical, often in the language of disorder, disease, and illness” (Conrad, 1992, as cited in Hutson, 2019, p. 111). As spoken about in the *Control and Neoliberal Ideologies* section above, women are seen as solely accountable and blamed for their weight. Part of this culturally endorsed blame is due to fatness being framed as a medical issue and as a ‘public health crisis’ (Boero, 2012; Hutson, 2019). In 2013, against the counsel of the national scientific committee, the United States announced that ‘obesity’ was a disease (AMA Council on Science and Public Health, 2013, as cited in Meadows & Daníelsdóttir, 2016). NAAFA (2015) commented on this, saying:

> This tactic from the medical industrial complex medicalizes fatness in order to declare “obesity” a chronic disease that requires treatment and, thereby, reimbursement from insurance companies, legitimating the iatrogenic “treatments” for weight cycling that

> make higher weight people sicker in the long run. (para. 4)

Medical guidelines continue to encroach on personhood. Apovian et al. (2015) and Tucker (2015) reported on guidelines from the Endocrine Society where the treatment of 'obesity' was deemed as first priority. Meadows and Daníelsdóttir (2016) commented critically on these recommendations that "prioritize weight management over clinical effectiveness and tolerability in prescribing choices for conditions such as schizophrenia, epilepsy, depression, and HIV" (p.2). Further, this ignores copious empirical evidence showing that the health of higher-weight people is comparable or better than 'at weight' people (Clark et al., 2014; Ghoorah et al., 2016; Hainer & Aldhoon-Hainerová, 2013, as cited in Pausé, 2012).

This pathologizing and medicalization is negated by *set point theory*, where research shows that the brain has a set point for weight that it endeavours to continually return to (McHugh & Kasardo, 2012). Set point theory contradicts the idea that weight is completely under a person's control or willpower and supports the fact that the body will self-correct regardless of diet efforts. Scholars refer to this theory in support of the facts showing that the majority of people regain the weight they lost within 3-5 years of dieting (Tovar, 2018). Many regain more. People have naturally occurring lower or higher set points, and research shows that extreme diets can actually increase a person's set point (Coon & Mitterer, 2010). Medicine also ignores the minority stress model, which takes into account the adverse effects of stigma, prejudice, and discrimination that marginalized people experience as chronic stress (Meyer, 2003). Chronic stress has been linked to the development of cardiovascular disease, diabetes, cancer, depression, anxiety, autoimmune disorders, et cetera (Mariotti, 2015). "Critically, the harms associated with a hostile environment occur even in the absence of actual stigmatizing incidents – stigmatized individuals go through their daily life anticipating, fearing, expecting and

preparing for these events" (Meadows, 2018, para. 7). The physical, emotional, and psychological stress endured activates the body's threat systems and responses.

Pausé (2012) spoke to the canonized belief of fat bodies being an affront to and a drain on health resources: "in countries with public health systems, this [is] highlighted in campaigns that suggest that the taxpayer is being burdened by the health costs of the fat people in society" (p. 45). This rhetoric, with designed consequences, has been internalized by health practitioners. 'Obesity' is erroneously blamed as a risk factor, and even a cause, for diseases including diabetes, heart disease, cancer, etc. (Gard & Wright, 2005). There is an abundance of studies within the last century, which vary in funding sources and bias, that either confirm or deny these claims. Wooley and Wooley's (1983) research showed that these internalized biases skew treatment, as "no [practitioners] seem to take seriously the risk to health caused by repeated weight fluctuations" caused by dieting (p. 884). This section of the capstone is not focused on expanding upon the error of conflating correlation and causation, but on the impact of public and medical discourse. Numerous studies spanning decades found that "fat women are more likely than non-fat women to cancel or postpone appointments with health care providers for fear of being reprimanded or harassed by health care providers" (Carryer, 2001; Jutel, 2001; Olson, Schumaker and Yawn, 1994, as cited in Pausé, 2012, p. 48). Puhl et al. (2013) specifically found that 19% of fat women would avoid further medical appointments, and 21% of fat women would look for a new doctor if stigmatized based on their weight by their doctor.

While the organized control exerted by diet culture and fat phobia harms all people, when deployed against fat women, this persecution is tantamount to femicide (Dean, 1979; Fishman, 1998; Tovar, 2018). "Gaining weight in the current historical era means doing so within the context of the obesity 'epidemic'–what scholars have called a 'moral panic' over body size"

(Campos, 2004, as cited in Hutson, 2019, p. 110). Fat women are dying trying to live a life free from oppression through starvation cycles, discrimination, and medical malfeasance. Restraint theory also impacts chronic dieters, as this suggests that when eating is restricted the scarcity mindset is activated and produces the opposite reaction of eating more, potentially leading to binging practices (Herman & Polivy, 1975; Polivy & Herman, 1985). Women are attempting to discern which of their behaviours are 'good' and 'bad' based on medical directives, ascribing moral rules to existing in one's body (Hutson, 2019). Medical terms have led to deficit-focused language, which shape lived experiences (Jordan & Tseris, 2018).

Bias in Psychology

Fat bodies exist at the intersection of all forms of oppression. Felkins (2019) denounced the erasure of fatness in theories as fat bodies are at "risk from surveillance and violence from the state and it's institutions": "fatness and size must be included in intersectional [theory, praxis, and] analysis, because our material bodies are more vulnerable than our theoretical selves" (p. 184). This supports the idea that the elimination of fatness in psychological theory actively enacts harm, which violates ethical practice. Fat is hypervisible and can therefore be psychologically damaging due to the severity of anti-fatness. Aza (2009, as cited in Kinavey & Cool, 2019) further built on how interpersonal relationships of fat women are affected by stigma and bias, naming that the therapeutic relationship is also impacted. As mentioned in chapter one, psychology is rooted in harmful white, patriarchal, and colonial theories (Arthur, 2018), thus the internalization of anti-fat bias and false health equivalencies is probable in the field. Akoury et al. (2019) noted that while anti-fat bias exists in mental health practitioners, few studies actually existed analyzing this specific group's sizeism and their practices with fat clients (McHugh & Chrisler, 2019). "Psychotherapy should be a safe haven for all bodies, in all of their diversity.

Yet, given that bodies are sites of injustice, our therapy rooms can be sites of injury instead" (Kinavey & Cool, 2019, p. 116).

The American Psychological Association (APA) uses and promotes a medicalized view of fatness—a disease model with oppressive terms—pathologizing bodies and assigning blame (McHugh & Chrisler, 2019). Alarmingly, Caplan (2011) reported that authors of the DSM-5 considered adding and classifying 'obesity' as a mental illness. While the proposal was removed, this speaks to the larger discourse and prevalence of anti-fatness among mental health practitioners and the public (Caplan, 2011). In 2013 the DSM-5 did recognize that "non-Western persons are less likely to express fear of gaining weight," and therefore removed *fat phobia* as a condition of anorexia nervosa to "improve the cross-cultural validity of the disorder" (Parameshwaran & Chandra, 2018, p. 82). This underscores the cultural role of oppression, as dictated by white supremacy and western colonial beliefs. As recently as 2018, the APA Council adopted an official policy that named behavioural treatment for 'obesity' and 'overweight' children/adolescents using BMI and centering weight management (McHugh & Chrisler, 2019). McHugh and Chrisler (2019) stated that "organized psychology has joined the *war on obesity* … [and] Fitzgerald (2008) argued that acting on this flawed knowledge base may inflict harm on clients, a violation of the first principle of medicine: *Do no harm*" (p. 12).

Training & Schooling. Body-based oppression grounded in anti-fatness is not proactively or expansively addressed in training or schooling for mental health practitioners (Kasardo, 2019; McHugh & Kasardo, 2012). A systematic review of the knowledge base of psychology revealed that psychology still defers to a medical model paradigm (Touster, 2000 as cited in McHugh & Kasardo, 2012; see also Kasardo, 2019). As recently as 2000 to 2010, fat oppression was not even recognized as a form of prejudice in psychology curriculum (Poet et al.,

2011). “The neglect of sizeism or fat identity in undergraduate psychology courses, graduate courses on multicultural counseling, advanced training in diversity issues, and even clinical supervision is surprising, but well documented” (McHugh & Kasardo, 2012; Watkins & Gerber, 2016, as cited in McHugh & Chrisler, 2019, p. 8). Due to this omission of body-based oppression and body size as part of intersectional identity, anti-fatness operates in clinical practice with research showing impacts in both diagnosis of clients and in their treatment (Kasardo, 2019; McHugh & Kasardo, 2012). For example, in a clinical setting, mental health practitioners rated clients in larger bodies more negatively on a number of aspects of psychological functioning and “expected less effort” from them (Davis-Coelho et al., 2000; McHugh & Kasardo, 2012, p. 622). Pausé (2019) reinforced this when they stated that therapists make assumptions and expect negative outcomes more often for fat clients.

An interdisciplinary field has recently emerged called Fat Studies, and activist Marilyn Wann is recognized as originating the term (Rothblum, 2012). The field has its own journal, *Fat Studies*, edited by Esther Rothblum, who is named as the leading psychologist within this dynamic arena of study (McHugh & Chrisler, 2019). Fat studies “critically examines societal attitudes about body weight and appearance, and advocates equality for all people with respect to body size… ask[ing] why we oppress people who are fat and who benefits from that oppression” (Rothblum, 2012, p. 3). The incorporation of Fat Studies into the field of psychology is necessary for anti-oppressive, trauma-informed, and intersectional work.

Pathology & Profit. Also vital to mental health and well-being is the necessity of unequivocally “reject[ing] the idea that fatness is only ever a product of trauma, mental illness, or imbalance” (Tovar, 2018, p. 25; see also Chalklin, 2016). This pathologizes bodies (Donaghue & Clemitshaw, 2012) and implies that there needs to be a negative basis or disorder causing

fatness, adding to bias and prejudice due to shame and untruths. Fatness is thus medicalized and erroneously seen as a sign of psychopathology, with psychiatry further positioning fatness as an addiction (Ziauddeen et al., 2012; see also Parr and Rasmussen, 2012, as cited in Brown-Bowers et al., 2016). Psychological research predominantly disregards fat oppression, and when fatness is discussed, it is within the framework—and with the assumption—that being fat is pathological and that weight loss will be the by-product of healing (Kinavey & Cool, 2019; McHugh & Kasardo, 2012). Treatment focusing on weight loss and weight-management is oppressive and enacts anti-fatness; psychology is thus profiting from the diet industry. A full exploration of weight loss treatment and the resulting immeasurable harm/distrust of therapists is beyond the scope of this capstone.

Back in 1979, women in the Fat Underground repudiated medical and cultural stereotypes, saying directly to fat women: “it’s not because you’re weak willed, it’s not because you have no discipline, it’s not because you’re oral, it’s not because you’re neurotic... It’s because it is your body’s nature to be fat. That is the reason” (Dean, 1979, 32:53). Being ‘oral’ is a direct commentary on Freud’s psychosexual theory of development (Wade et al., 2016), revealing the harm psychology has inflicted upon people in bigger bodies. In fact, back in the 1980’s Wadden and Stunkard (1987) reviewed 500 studies across both the United States and Europe that refuted popular opinion and earlier ‘studies’. As McHugh and Kasardo (2012) summarized, “Wadden and Stunkard (1987) concluded that there is no evidence of greater psychopathology among fat people than among [straight-sized] people” (p. 620). There was indication of people experiencing ‘disturbances’ as a result (not a cause) of living in a bigger body (Wadden & Stunkard, 1987), which is in line with current findings of people experiencing stigma and body-based oppression.

Susan Wooley, professor of Psychology and widely published author in eating disorders, questioned if it was ethical to treat 'obesity' back in 1983. Wooley and Wooley (1983) noted:

> The treatment of obesity has derived from the assumption that fatness was due to abnormal behaviour … treatments sought to correct psychological causes of excessive eating, to educate people on proper diet and exercise, and to use learning theory techniques to systematically modify behaviour. The results of these efforts have been, on the whole, discouraging. (p. 884)

Thus, research has shown for decades that psychological treatment of fatness not only did not work but may have caused further harm to people. A psychologist and eating disorder specialist commented on this alarming issue, creating the expression *data-resistant researchers* for practitioners in the weight-loss industry (Bruno, 2013; see also Burgard, 2010). Research about the failure of specific behavioural treatment for fatness named "the stigmatization of obesity, the overstatement of health risks, and the pervasive influence of the lucrative diet industry" for the continued demand for treatment in the face of overwhelming facts (Garner & Wooley, 1991, p. 729). Perpetuating harm through the repeated use of ineffective treatments is evidenced within types of eating disorder treatment. Research has shown that using cognitive behavioural theory (CBT) for fat people with certain eating disorders was ineffective, yet CBT continued to be considered the 'gold standard' (McDermid, 2022). McDermid (2022) criticized the use of CBT as fat people were not included in the original studies to prove efficacy; the theory and research are failing, not the person. Brown-Bowers et al. (2016) researched manuals for treating binge-eating disorder and found embedded anti-fatness—such as treatment of fatness versus treating the disorder and symptomatology—that calls sanctioned interventions into question. They specifically questioned the safety, efficacy, and credibility of current treatments (Brown-Bowers

et al., 2016). While a specific focus on eating disorders and the detailed treatment practices addressing them are beyond the span of this capstone, these examples further showcase the reproduced anti-fat stigma within psychology.

Microaggressions & 'Advice'. A study by Akoury et al. (2019), which used semi-structured interviews with women, "examined weight-based microaggressions in a therapeutic context" (p. 98). They found that counsellors may be less likely to openly display anti-fat bias, yet express anti-fatness in microaggressions. *Microaggressions*, as defined by Sue (2010) are "everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership" (p. 3). Microaggressions have even been found to cause greater harm than overt prejudice in some instances because they are more difficult to identify and result in the victim questioning reality (Salvatore & Shelton, 2007; Sue, 2010; Yosso et al., 2009, as cited in Akoury et al., 2019). "Further, the power differential inherent in psychotherapy may make clients particularly unlikely to speak out against a perceived offense and more likely to doubt their own experience" (Akoury et al., 2019, p. 98). Common microaggression themes that arose from this study were: an over-focus on weight, less interest in clients with bigger bodies, and non-inclusive waiting room options. A qualitative study by Schafer (2014) also found an over-focus on weight, with clients expressing that therapists misinterpreted presenting issues as being caused by weight and suggested weight loss for resolution. Additional disturbing 'advice' that clients have received from therapists include: self-love being dangerous, using a lawn chair as the office chair broke, and picturing diabetic necrosis when bingeing to induce shame (Kinavey & Cool, 2019). These types of bias and harm

undermine clients' healing and lead to avoidance of fat people pursuing care for their mental health.

Politics of Care

Fat Liberation is focused on the humanization of all bodies and the reduction of prejudice (Chalklin, 2016). As liberation is freedom from oppression, as well as legal and social justice, access to non-biased medical care is critical to the rights and dignity of fat people (Walker, 2015). Countless studies have confirmed implicit anti-fat bias in health professionals. Implicit bias indicates unconscious negative associations that have real, measurable impacts: "in addition to affecting judgements, implicit biases manifest in non-verbal behaviour towards others, such as frequency of eye contact and physical proximity" (Fitzgerald & Hurst, 2017, p. 2). A study by Teachman and Brownell (2001) of 84 health professionals who 'treat obesity' found both strong attitude and stereotype implicit anti-fat bias, with only marginal explicit bias. Another study by Fitzgerald and Hurst (2017) analyzed 42 peer-reviewed articles published in psychological and life science journals from 2003 to 2013. This study examined "the influence of patient characteristics on healthcare professionals' attitudes, diagnoses, and treatment decisions", finding a "significant positive relationship between level of implicit bias and lower quality of care" (Fitzgerald & Hurst, 2017, p. 1). Therefore, the weight of a client is likely to elicit bias, which impacts treatment decisions and ethical care.

Foucault's (2003, as cited in Murray, 2007) *clinical gaze* also influences the politics of care through power dynamics; it is a tool that allows healthcare practitioners to observe, record, and comprehend disease. Murray (2007) commented on the fact that "empirical observation is never neutral, but always laden with cultural meanings, specificities, and prejudices" (p. 361). This non-neutrality impacts the scientific community's understanding of—and allocation of—the

binary categories of ‘normal’ and ‘pathological’ (Murray, 2007). Forcing bodies into intelligible categories disregards the socio-cultural impact of these classifications in larger societal discourse (Murray, 2007). Murray spoke to how the power of the clinical gaze and the power dynamics of the “rational figure” of the healthcare practitioner and the patient/client interact to suppress diversity and “tacit bodily knowledge” (p. 361). Additionally, it was found that therapists inaccurately assume that they themselves do not have anti-fat bias (Pausé, 2012). Thus, this assumption plus the power of the clinical gaze and binary categorization, creates an environment predisposed for enacting harm with fat clients.

As mentioned in chapter one, it is vital to avoid re-traumatizing people in fat bodies in therapy. There is a risk of both conscious and unconscious harm by the therapist, as mental health professionals define both health and morality in the assessment of treatment (Médiné, 2021a). Thus, “counsellors serve as agents of social control; however, they are also potential agents of social change” (Estefan & Roughley, 2018). According to ethical standards and feminist principles, clients are the expert in their lived experiences and should be deferred to regarding both what their experience of health is and their own relationship to their body (Médiné, 2021a). Scholars in feminist and gender studies, as well as community health, are criticizing the recent superficial clinical guidelines of asking practitioners to be sensitive to anti-stigma, as opposed to enacting true fat liberation (Orsini & McPhail, 2020). Orsini and McPhail (2020) commented that weight continues to be pathologized as a disease, and these “structures and systems that devalue fat bodies” impacted the growth of the psychological field by capitalizing on ‘abnormality’ (para. 6).

Disability justice overlaps with Fat Liberation in the call for accommodation and anti-discriminatory laws, and in challenging the norms that devalue bodies, seeing them as needing

'fixing' (Eisenmenger, 2019; Smith, n.d.). There are "basic frameworks for understanding the development of a minority (non-dominant) identity" (Pausé, 2012, p. 53). Jordan and Tseris (2018) also noted the importance of deconstructing all universal models "from both feminist and critical disability perspectives, in order to locate, understand and celebrate diverse developmental experiences" (p. 427). Part of this is the recognition that pejorative uses of the terms 'unhealthy' and 'abnormal' strip people of their humanity. In 2012 Pausé questioned why there is no research on the developmental processes—like other models—for the acceptance of fat identities. Within that questioning was an acknowledgement that many existing models are flawed, presuming linear progression and devaluing the impact of context and relational facets (Pausé, 2012). This lack of research echoes the erasure of fatness from theories combined with bias within the field. Kaufman and Johnson (2004) commented on the importance of recognizing the infinite nature of stigma and tailoring care for stigmatized individuals. The management of stigma is never 'resolved', continuing throughout a person's life, and the acknowledgment of this is necessary in order to center a fat person's intersectional identity (Kaufman & Johnson, 2004).

Current Approaches with Fat Clients

Mainstream fat-positive approaches are scarce, and as previously mentioned, there is an erasure of fatness in theories. The National Association to Advance Fat Acceptance (NAAFA) summated hopeful steps of the views of oppressed groups: "many oppressed groups have been seen first as sinful, then as sick, and it is only with great effort and social progress that they are finally recognized as intrinsically whole, worthy, and not somehow less than the dominant group" (NAAFA, 2015, para. 5). It is critical for ethical practice to work from a trauma-informed, anti-oppressive, fat-positive lens that views this oppressed group not as sick, but as the normative expression of body diversity. As Burgard (2010) said, "the first order of business is to

understand that all bodies, of all sizes, are precious and deserve care" (p. 21). Further, Kinavey and Cool (2019) declared:

> We believe that body liberation is a vital concept for all therapy, not simply an abstract ideal attached to the area of eating disorders and body image concerns. There is no reasonable ethical argument against advocating for body liberation, which includes supporting weight-inclusive communities and approaches, encouraging fat acceptance, and addressing the deep familial, cultural, and systems-based perpetuation of anti-fat bias. (p. 116-117)

With these tasks in mind, Health at Every Size (HAES), a therapists' weight neutral stance, and queering therapy are explored.

Health at Every Size

Health at Every Size (HAES) is "grounded in social framework that offers a counter-focus to mainstream health discussion in clinical work" (Kinavey & Cool, 2019, p. 117). HAES is noted as a model that counters the medicalization and pathologizing of higher weight people (Kinavey & Cool, 2019). HAES has been encouraged by NAAFA and the Council on Size and Weight Discrimination (Bacon & Aphramor, 2011). The approach that HAES offers includes five principles last updated in 2013: weight inclusivity, health enhancement, respectful care, eating for well-being, and life-enhancing movement (Association for Size Diversity and Health [ASDAH], 2020). Expanding upon these principles, HAES does not advocate weight loss or being 'healthy', instead espousing acceptance and respect of body diversity, intuitive and balanced eating (including pleasure and hunger cues), enjoyable and appropriate physical activity, and an understanding that health and well-being exist on a continuum and are multidimensional with numerous interacting spheres (ASDAH, 2020). There is, however,

criticism of HAES that exists in literature and community. This criticism derives from the potential connection to healthism, where some have applied this framework and used the notion of 'health' to indicate worth and morality of a person. Thus, HAES should be used with a critical and fat liberationist lens.

Acceptance is key, as working towards body acceptance has been found to offer people psychological benefits (Cassone et al., 2016). Bacon and Aphramor (2011) examined numerous randomized controlled clinical trials that were built explicitly on size acceptance, and they found that:

> A HAES approach is associated with statistically and clinically relevant improvements in physiological measures (e.g., blood pressure, blood lipids), health behaviors (e.g., eating and activity habits, dietary quality), and psychosocial outcomes (such as self-esteem and body image), and that HAES achieves these health outcomes more successfully than weight loss treatment and without the contraindications associated with a weight focus. (p. 2)

These positive results were repeated by numerous studies since, with HAES-informed approaches reducing dieting behaviour and anti-fat beliefs while increasing energy, body-esteem, and psychological health (Berman et al., 2016b; Humphrey et al., 2015; Penney & Kirk, 2015, as cited in Pausé, 2019). Thus, the HAES approach has been proven to be both efficacious and ethical, disproving the false myths that medicalization upholds. The 'paradigm shift' that this approach advocates for is still noted as being on the edges of the therapeutic field (Bacon & Aphramor, 2011).

Therapist: Weight Neutral Stance

NAAFA created guidelines in 2010 that encouraged a weight neutral stance for therapists practicing with fat clients. NAAFA (2010) defined this as a therapist not making weight-based assumptions about their client and not connecting weight with healing outcomes. Burgard (2010) also promoted a weight neutral stance for healthcare professionals. They stated that the "treatment plan should not depend on the patient's body size, [clarifying that] we do not have an intervention to permanently and safely change weight … the pursuit of weight loss is one way that many people get stuck developmentally" (Mann et al., 2007, as cited in Burgard, 2010, p. 24). Thus, engaging in treatment plans to 'change' weight is harmful to overall wellness and mental health due to the likelihood of weight cycling (Bacon & Aphramor, 2011; Burgard, 2010). This data-resistance in healthcare driving anti-fatness is a continual ethical failure (Bruno, 2013). Weight neutrality, or *body neutrality*, is criticized by many in the fat community as those in larger bodies do not have the luxury of ignoring the site of their oppression: their body (Gordon, 2020b; Taylor, 2018). They also state that personal body neutrality does not address the larger forces of body-based oppression. However, NAAFA and Burgard are not advocating for neutrality on a personal level, but neutrality on a broader healthcare level that can allow for addressing bias personally and community wide. They stated their "attempt to make the therapeutic setting a weight neutral oasis, a subculture where weight has little inherent meaning, so that patients can sort out what truly troubles them and find effective solutions" (p. 25).

Queering Therapy

As the therapeutic alliance has been shown to be the most important factor for therapeutic progress and outcomes (Flückiger et al., 2018), addressing barriers to this relationship is essential. Pausé (2019) stated that bias and assumptions are two such barriers and offer

'queering' as a solution: a framework and method to support therapists in shifting their perspectives by becoming uncomfortable and confronting common beliefs about fatness. Wykes (2014) described *queering* as a "mode of political and critical inquiry which seeks to expose the taken-for-granted assumptions, trouble neat categories, and unfix the supposedly fixed alignment of bodies, gender, desire and identities" (p. 4). This theoretical framework has been applied to multiple fields. In the therapeutic field, an ethical practice is provided by the therapist critically thinking about the specific needs of their fat clients, through the recognition of personal bias, engaging with the work of fat people and activists, and providing size inclusive physical environments (Pausé, 2019). The queering of fatness challenges assumptions through questioning: are they true, socially constructed, and/or beneficial to client or therapist? Thus, the lived reality of fat clients is centered through queering fatness (Pausé, 2019), and contributes to trauma-informed, ethical care.

Specific Interventions

Shame

There are large gaps in the psychology field regarding fat-positive practice. In terms of specific interventions, Westermann et al. (2015) was the first to study reactions to social exclusion experienced by people in larger bodies. They found that fat people suffered a particular increase in shame in response to social exclusion due to anti-fat bias. This finding led to Westermann et al. suggesting that psychological interventions focused on shame may be fundamental for work with clients. McHugh and Chrisler (2019) also specified shame as crucial to the work with fat clients, having stated that "a [higher weight] in women is associated with higher instances of depressive episodes and increases in suicidal ideation and attempts (Teachman et al., 2003), which may be traceable to shame" (p. 14). Additionally, McHugh and

Chrisler explored *fat shaming*, defined generally as humiliating/mocking/criticizing fat people. From studying women and shame (Brown, 2007) to her most recent works, Brené Brown (2013) has defined *shame* as an "intensely painful feeling or experience of believing that we are flawed and therefore unworthy of love and belonging—something we've experienced, done, or failed to do makes us unworthy of connection" (para. 2). Common effects of shame are avoidance, withdrawal, and feeling isolated (McHugh & Chrisler, 2019). As evidenced throughout this capstone, fat women are at risk of internalizing and experiencing shame due to body-based oppression. Microaggressions enacted by therapists can cause additional self-blame and shame, leading to avoidance and evasiveness from clients, harm, and rupture/interference with therapeutic goals (Akoury et al, 2019; Brown, 2007; McHugh & Chrisler, 2019; McHugh & Kasardo, 2012). "Thus, it is important for therapists who work with fat women to understand the psychological impact of shame" (McHugh & Chrisler, 2019, p. 14).

Psychoeducation & Activism

It is critical to shift blame from the individual client to larger oppressive systems. Matacin and Simone (2019) commented on this, noting that "conventional therapeutic suggestions for addressing weight concerns focus on self-discipline rather than on the larger social, cultural, or political contexts of weight stigma" (p. 200). This shift aligns with the research into eating disorder prevention by Stice et al. (2013), where they suggested educating clients about internalization of societal and cultural pressures through deconstruction. Efficacious feminist therapy tenets include consciousness raising, social and gender-role analysis, and resocialization (Israel & Santor, 2000, as cited in Matacin & Simone, 2019). Examples of topics for exploration in a therapeutic setting include: "connecting one's lived experiences to sizeism (consciousness raising), becoming aware of how the thin-ideal has

negatively affected one's life (social and gender-role analysis), and/or restructuring one's cognitive constructs in regard to body size/weight (resocialization)" (Matacin & Simone, 2019, p. 204).

Feminist counselling has recognized the relationship between individual change and social change and has proposed activism as an intervention (Matacin & Simone, 2019). Numerous studies have found that fat activism supports psychological well-being and challenges prejudice and bias on a systemic level (Cooper, 2016; see also Hesse-Biber, 2007; Maine, 2000; Solovay & Rothblum, 2009; Wann, 2009 as cited in Matacin & Simone, 2019). Ali and Lees (2013) advised caution and collaboration with clients to ensure that this intervention is helpful and positive for a client's well-being. Part of this discussion may be offering specific works of fat activists and resources. Psychoeducation is also critical for therapists working with fat clients for guidance, research, and activism. This is one of the social justice steps that will be listed in chapter three.

Summary & Synthesis

This literature review encompassed recent and relevant scholarly peer-reviewed sources as well as a variety of marginalized voices from within the fat community, including activists, thought-leaders, and liberation-based practitioners. Factors contributing to and sustaining oppressive anti-fat/diet culture literature and media were analyzed, illuminating the racist, violent, and control-based origins of anti-fatness. The language of body trauma was exposed, showing how oppressive language needs to be updated and based on individual identity and choice. Harm in healthcare was shown to be pervasive through the medical industrial complex and deep bias in psychology showing up in the therapeutic space. Current trauma-informed healing modalities for fat bodies were summarized, including health at every size, a weight

neutral therapeutic stance, and queering therapy. The information examined in this chapter will be used in the creation of trauma-informed and anti-oppressive resources for chapter three.

Chapter 3: Discussion

This chapter will be a culmination and conclusion of the research and analysis within this capstone. I will offer an accessible psychoeducational step-by-step resource for therapists to expand the depth and breadth of their knowledge to both engage in fat-positive practice and support fat liberation. These steps will be based in social justice learnings. There will also be valuable themes noted and tools offered to use with clients for clinical implications. The need for revolution in the therapeutic field is echoed by Brown-Bowers et al. (2016) who invited this profession to fulfill the ethical and moral guidelines it set out to:

> We would like psychology to locate the problem of fat shame in society, as opposed to the individual person's body (and/or mind). Stemming from this, we would like practitioners to provide individuals with tools to identify, understand, and resist shame, stigma, and oppression, rather than provide them with tools to reshape their bodies. (p. 34)

This chapter is my interpretation of the research and a call to action for all therapists to engage in ethical practice and to advocate for their clients.

Social Justice

As anti-fatness is comprised of individual experience and expressions of bigotry and systemic institutional policies that oppress fat bodies (Gordon, 2022), the response must equally encapsulate both the micro and macro while prioritizing harm reduction. With Taylor (2018) and Kinavey and Cool (2019) naming the body as the site of injustice, the therapeutic work to address body-based oppression is social justice work. Engaging in this practice establishes therapy as political because it challenges structural oppression (Boggan et al., 2017). Thus, the suggested tools for therapists to engage in are based in social justice, such as Durand's (2021) six

actionable steps for Allyship, McDermid's (2022) framework for fat-positive practice, Pausé's (2019) *Queering Fat Therapy*, and Kinavey and Cool's (2019) *Ten Ways to Shift Your Therapeutic Lens.* Specifically, in response to the research within this capstone, it is recommended that therapists embody anti-oppressive practice. *Anti-oppressive practice* incorporates the diverse social identities of the client and therapist, acknowledging the clinical relevance of privilege and systemic barriers (Brown, 2019). This meta-method of therapy extends to therapist advocacy, effecting change in the community and larger society (Brown, 2019). Anti-oppressive practice supports an anarchist framework, which means working against all social hierarchies. Anti-ableism principles are key tenets of this framework as well, focusing on the fact that "no body is disposable" (ASDAH, 2019). Thus, each other's liberation is our own (Luna, 2021; ASDAH, 2019).

Step-by-Step Resource for Therapists

I acknowledge that these are not the only steps, nor are they the only correct way to support fat liberation. The following is based on my research and draws on the work of fat practitioners, activists, queer theory, anti-racism, and anti-ableism, as well as information from the fat acceptance and fat liberation movements. Kinavey and Cool (2019) confirmed that "anti-fat bias is not something we can change by simply being aware of our own thoughts and behaviours" (p. 7). Therefore, these suggestions also draw upon the work of Breton (1984, as cited in Kinavey & Cool, 2019) who said, "the power to name must be accompanied by the power to act" (p. 36). This is also encapsulated by the use of Love's (1997, as cited in Kinavey & Cool, 2019) 'liberatory consciousness' to change systems of oppression: awareness, analysis, action, and accountability. The listed steps below ask for conscious and continual work of counsellors to revolutionize practice.

1. Do your own work.
2. Recognize your potential to cause harm and be receptive to feedback.
3. Listen and believe fat people.
4. Engage in education through consumption of work from fat activists and attend trainings from fat practitioners.
5. Change the therapeutic space to be truly accessible and representative.
6. Update the language and terms you use.

In the first step, therapists are tasked with doing their own work. Brown-Bowers et al. (2016) affirmed that it is impossible not to have absorbed anti-fat bias given the pervasive sociocultural discourse. Therapists must honestly assess themselves by recognizing and confronting their own anti-fat bias. Engaging in healing work as a practitioner "involves examining our own body stories, including our personal history with disordered eating and dieting … [and to] consider whether [our] own beliefs about 'health', food, and body are informing the recommendations [we] make to clients" (Kinavey & Cool, 2019, p. 9). Further, it is essential to contemplate the largescale goals of 'health' and well-being within counselling, and to consider the overvaluation and assumptions involved in applying a specific understanding of these concepts to clients. In addition, the types of questions that a practitioner may ask themselves include: what are my beliefs about people in larger bodies? What is the default body type, and do I equally believe that some people are naturally thin, and some people are naturally fat? How do I currently work with fat clients and what approaches do I use?

In the second step, therapists are asked to recognize their potential to cause harm and be receptive to feedback (Durand, 2021). This step is tied directly to the *Harm and Experiences in Healthcare* section above and acknowledges the power differential inherent in the therapeutic

relationship (Durand, 2021; Paré, 2013). Kinavey and Cool (2019) expanded upon this ethical duty, stating that "[therapists'] biases about weight can impede our clients' healing process … our own projections about body size shut down the potential for a depth of exploration that could invite body acceptance" (Kinavey & Cool, 2019, p. 9). Further, no therapist can diagnose through sight: body shapes and sizes are not an indication of health (Kinavey & Cool, 2019; see also McHugh & Chrisler, 2019). There are tests that support this exploration, one being the Harvard *Implicit Association Test* for weight (https://implicit.harvard.edu/implicit/). Project Implicit (n.d.) was founded by scientists Dr. Tony Greenwald, Dr. Mahzarin Banaji, and Dr. Brian Nosek in 1998 with the intention to uncover hidden biases through timed associations of size and stereotypes/evaluations (Pausé, 2019). Being receptive to feedback is ongoing throughout one's career and life; this includes being open to and checking in for direct and indirect feedback from clients. Durand (2021) noted that when someone engages in emotional labour through giving feedback or correcting, the receiver should say "thank you" and not rush to explain/defend, as "it is a privilege to *learn about* oppression rather than to *experience it* for yourself" (para. 12). Mia Mingus (2019), a queer, disabled, Korean writer and educator for transformative justice and disability justice, has offered steps for accountability and genuine apology following harm. Mingus prefaced this work by stating, "within the world of transformative justice, accountability is the ecosystem in which apologizing lives. Accountability is simultaneously complex and simple, concrete and ever changing" (para 8). The process of accountability is allocated into four parts: self-reflection, apologizing, repair, and behaviour change (Mingus, 2019). Self-reflection is the recognition of harm and desire for remedy, apologizing involves showing understanding and vulnerability, repair is the beginning of

rebuilding trust and happens in relationship over time, and behaviour change is comprised of transformation and may necessitate further support (Mingus, 2019).

In the third step, therapists are asked to listen and believe fat people. This step involves searching out fat positive spaces and listening to the stories and personal anecdotes given, as well as elevating community voices. Believe fat people when they speak about the harm they have experienced and validate their humanity. This is a pointed exercise in de-centering oneself as an expert in the therapeutic space (Meadows & Daníelsdóttir, 2016; Médiné, 2021a). Practitioners are encouraged to challenge themselves to listen without applying personal frameworks for experience, as they may not have one, especially those with thin privilege.

The fourth step encourages therapists to educate themselves: a practice of both unlearning and learning. Research shows that education and empathy are important factors in changing attitudes towards fat people and rejecting dieting as the solution to systemic oppression (Pausé, 2019). This may look like reading, watching, and/or consuming content in various forms. Pausé (2019) explained that changing anti-fat beliefs/practices is difficult, and education and evoking empathy through humanization can be found in "consum[ing] fat-positive material produced by fat people" (p. 83). I implore therapists to pay for trainings from fat practitioners; support the websites of those whose work you are learning from; buy books, watch shows and documentaries, and listen to podcasts made by and for fat people; support fat artists; follow social media accounts of fat people occupying all of the fat spectrum and of intersecting marginalized identities; and celebrate the beauty of resistance, liberation, and revolution every time you encounter it. These will provide a critical juxtaposition to the anti-fat content disseminated in the mainstream, such as the misery-porn seen on extreme weight loss shows

(Pausé, 2019). Proactive action can also include seeking out routine supervision from fat-identified and fat-positive practitioners.

The fifth step is to change the therapeutic space to be fat-positive, i.e., fully accessible and representative of all people. A trauma-informed space centers safety that is both emotional and physical. An office being a "space of equity" is the basic level and therapists should "at a minimum inform potential clients if there are spatial constraints or if access is limited to those who are able-bodied" (Kinavey & Cool, 2019, p. 10). Some questions that practitioners should ask about the physical space include: is there a variety of inclusive seating options? Are there seats without arms on them? This needs to be communicated to the public in an appropriate way that does not tokenize or make the client have to make a specific request (Pausé, 2019). After all, "if we cannot see the limitations of our own office furniture, how will we learn to see the limitations in our own belief systems?" (Kinavey & Cool, 2019, p. 118). Additionally, check the waiting area for pop culture/beauty/women's health magazines and other reading materials (Pausé, 2019). These magazines engage in diet-culture exploitation and fat shaming and are not only harmful but communicate to clients that they are unwelcome and unsafe. They also do not tend to be representative of all bodies and disabilities. Are there pictures on the walls? One can ask if the pictures and the artists include representation of fat people and are inclusive. Next, consider the building itself and clearly indicate the level of accessibility for potential clients regarding stairs, ramps, elevators, et cetera. The next item to consider is online presence. Is there respect for the inherent diversity of bodies and are they represented in the images and text on the website? If a practitioner has been engaging actively in fat-positive practices listed here, are they clearly naming fat liberation in their practice and what specific steps they continue to take? Lastly, another barrier to fat-positive care and unbiased care is financial access. As research

shows that fat people are negatively impacted across all arenas in life, including income and job opportunities (Fikkan & Rothblum, 2012, see also Flint et al., 2016; Jovančević & Jović, 2021), this will impact the ability of people in bigger bodies to access mental health care. Does the practice offer sliding scale options for people experiencing body-based oppression as they encounter increased economic barriers? Have practitioners considered a sliding scale option specifically for fat clients?

The sixth step is to update language from oppressive and harmful terms to neutral or empowering terms. This was explored in the previous section *The Trauma of Language*. Individuals should always be regarded as the expert in their identity politics. Akhoury et al. (2019) gave voice to clients in their research, and "participants advised therapists to allow their clients to initiate conversations about weight" (p. 93). It is also recommended that therapists ask for consent before engaging in body-based conversations, even if a client initiates, and to encourage feedback from clients about language used. Overall, as "professionals we should challenge ourselves to learn to speak with inclusive language about bodies and to avoid terminology that pathologizes or stigmatizes" (Kinavey & Cool, 2019, p. 10). In regard to oppressive terms, scholars and the fat community have asked for the slur *obesity* to be removed. Some suggest that best practice would be to use neutral terms, like 'weight' and 'higher weight', with higher weight meaning non-straight-sized. Also regularly seen in safe spaces is the use of 'person in a larger body'. It is critical to state that these terms will vary. As individuals are experts in their identity—and only if a client initiates a body-based conversation—ask the client what terms they use. Next is the word 'fat'. Saguy and Ward (2011) spoke about the reclamation of *fat* as a descriptor that is both neutral and normalizing by people in fat bodies. Part of this reclamation and renegotiation is not accepting anti-fat language and behaviour from other people

(Meadows & Daníelsdóttir, 2016; Saguy & Ward, 2011). Again, everyone is different and the use of this term should never be used without someone's expressed consent and without the client's initiation of the topic. Finally, the term 'fatphobia' enacts erasure and does not denote the scope of oppression. The terms that are gaining traction and that prioritize harm reduction are *anti-fat bias* and *anti-fatness*. Anti-fatness is defined as "the attitudes, behaviors, and social systems that specifically marginalize, exclude, underserve, and oppress fat bodies", referring "both to individual bigoted beliefs as well as institutional policies designed to marginalize fat people" (Gordon, 2021, para. 13). This means that these terms are more explicit and acknowledge systemic body-based oppression. Thus, the language used centers lived experiences and supports trauma-informed, harm reductionist, and anti-oppressive care.

Work with Clients: Clinical Implications

This capstone has sought to explore the lived experiences of fat people and western societal and cultural treatment of fat bodies, experienced as body-based oppression. It is not the objective of this chapter to provide hyper-detailed instructions for working with fat clients. Pausé (2019) explained why this would not be ethical:

> Taking the time to understand the individual needs of each fat client is also key to ensuring appropriate care. Fat people are not a monolith; they have a wide range of experiences and lead intersectional lives. The lives of fat people of color, for example, are very different from those of fat white people who benefit from white privilege (Pausé, 2014b; Shackelford, 2016; Yeboah, 2017). Fatness may be experienced differently depending on gender, sexual orientation, health status, ability level, class, and age among others. Many individuals also experience an intersection of oppressions; the oppressions they experience for being fat, for being queer, for being Black, all intersect to produce

> unique interactions with the larger society and different structural barriers to accessing resources and opportunities (Crenshaw, 1991). (p. 86)

With this said, there are some fat-positive and resistance-based suggestions for revolutionizing practice, supporting clients through a liberationist lens, and celebrating their full humanity. Of critical importance is the recognition that any suggestions or recommendations are not meant to be used in place of crisis care, i.e. with clients who require hospitalization.

Psychoeducation & Externalization

Brown-Bowers et al. (2016) recommended a focus on exposing weight-related myths through content on shame, stigma, oppression, and anti-fat bias. They also advocated for "therapists to address the ways in which our society's continual barrage of negative messaging is detrimental to the psychological and physical well-being of fat people" (Brown-Bowers et al., 2016, p. 33). Kinavey and Cool (2019) echoed the power of psychoeducation, and they suggested a focus on language and its origins. As indicated in this capstone, terms used to label bodies hold significance and can enforce oppression or support healing. The work undertaken and accomplished in the *Step-by-Step Resource for Therapists* section will aid in providing psychoeducation to clients and broaching this topic in the therapeutic space. Other topics that support anti-fatness to be addressed are the construct of gender, objectification theory, patriarchy, white supremacy, classism, and ableism.

Other suggestions for supporting clients using a liberatory lens are using narrative and externalization techniques. "Name, dissect, and have conversations about diet culture with your clients. [This] will create opportunities to externalize the parts of diet culture that become internalized and potentially deepen the therapeutic process and create a milieu conducive to liberatory healing" (Kinavey & Cool, 2019, p. 8). Further, Kinavey and Cool (2019) proposed

that counsellors question their client's goal of a smaller body to fulfil cultural prescriptions. They noted that the support of this goal would support assimilation into systems of oppression. Body-based fat oppression is virtually inescapable, thus the social justice work to dismantle these systems is necessary for revolution, liberation, and saving lives (Kinavey & Cool, 2019). McDermid (2022) offered another crucial tool in her Fat-Positive practice guide, advising therapists not to ignore a client's goal of weight-loss. Addressing what weight-loss represents for the client is an important part of the therapeutic journey and an opportunity to unpack trauma. Weight-loss may be a part of a client's safety narrative or part of how the client deals with stigma by attempting to pass or through covering. This exploration supports the externalization process and can illuminate internalized critical narratives.

Trauma & Loss

The first step in trauma-informed care is to begin work to build a safe enough space. An integral part of this, according to McDermid (2022), is to clearly name bodies in the room and corresponding privilege. McDermid suggested that counsellors name their size identity and introduce gentle questioning around how the client feels about the naming and how the client feels to be witnessed in this. If the client names discomfort, this is an opportunity to engage in reparative work and strengthen the alliance.

Studies have continually espoused the link between oppression and negative mental/physical health outcomes. As previously mentioned, the minority stress model takes into account the adverse effects of stigma, prejudice, and discrimination that marginalized people experience as chronic stress (Meyer, 2003). Goodman and West-Olatunji (2008, as cited in Kinavey & Cool, 2019) also specifically stated that "exposure to body-based oppression can result in traumatic stress" (p. 7). Traumatic and chronic stress has been linked to the

development of cardiovascular disease, diabetes, cancer, depression, anxiety, and autoimmune disorders (Mariotti, 2015). Kinavey and Cool (2019) spoke to these symptoms and illnesses, advising counsellors to screen for trauma in clients who are oppressed and are impacted by anti-fat bias, and to use a trauma-informed approach in all aspects of client work. "Critically, the harms associated with a hostile environment occur even in the absence of actual stigmatizing incidents – stigmatized individuals go through their daily life anticipating, fearing, expecting and preparing for these events" (Chaudoir & Quinn, 2015; Hatzenbuehler et al., 2013, as cited in Meadows, 2018, para. 7). The physical, emotional, and psychological stress endured activates the body's threat systems and responses. Further, "people often disconnect from their bodies when they are seen as 'wrong,' whether because of size, race/ethnicity, gender expression, ability, or age" (Kinavey & Cool, 2019, p. 8). Thus, trauma-informed treatment must not reinforce neoliberal individual blame or shame. Somatic work must also take this into consideration: safety in body inhabitancy is paramount when broaching the subject of safe types of movement and movement for joy or creative expression.

In addition, counsellors are encouraged to expand the dialogue to acknowledge that mental health issues may be "an appropriate response to a fat-oppressive culture" (Kinavey & Cool, 2019, p. 8). This also includes validating shame as a response to the violence of oppression and bringing in opportunities to challenge this shame and potential internalized anti-fatness. As this trauma is held and understood in its context, grief and the experiencing of loss may arise. As spoken about in the *Psychotherapeutic Relevance* subsection, when letting go of the 'fantasy' of the idealized norm body a client may express grief, feelings of loss, and anger at those upholding anti-fat norms. Working with clients to address the scarcity mindset that may arise around these feelings and ensuring there is ample space for processing can support growth.

Acceptance & Resourcing

The HAES approach utilizes self-compassion paired with self-care. Self-compassion may also look like inner critic work. Radical acceptance tenets can be weaved into the therapeutic work alongside the client's goals shifting from assimilation to liberation. If being straight-sized is not the end goal, is it possible for the client to practice fat acceptance? Additionally, acceptance exists on a spectrum, and counsellors can explore and make space for the different definitions of their client's hopes/goals. Acceptance can be supported through resourcing the client. There is healing in community, and encouraging fat women to participate in safe groups and group activities addresses the isolation that shame and internalized anti-fatness can encourage. Are there fat-positive spaces in the local geographic area? Explore the benefits of community with fat clients. All of these clinical implications and dialogues are housed within safety, attunement, and witnessing. Fat people do not need to be fixed because they are not broken. Continue to sit in the pain with clients and be their witness. Compassionate questioning and exploration with deep care and attunement are part of the revolution.

Future Recommendations & Conclusions

This capstone has explored how the field of psychology has failed in its theories and application of anti-fatness, and the related call for revolution. Mental health practitioners have caused irrevocable harm to fat people and especially fat women, violating ethical practice. As fat bodies exist at the intersection of all forms of oppression, Felkins (2019) denounced the erasure of fatness in theories. Brown-Bowers et al. (2016) also spoke to the ethical need to center lived experience and marginalized voices from within the fat community moving forward:

> It is crucial to legitimate the subjectivities and embodied experiences of fat-identified participants, and particularly fat women, as valid sources of knowledge informing the

> theory and practice of psychology. In doing so, we will be better able to respect and facilitate the unique and diverse needs, barriers, strengths, and goals of fat people as they access and interact with the medical and mental health systems. (p. 34)

With this in mind, I recommend that new in-depth studies are created for fat people by researchers that are also fat and liberationist-informed. These studies can then inform mental health practitioners' work and the approaches that are utilized, while also creating a base of empirical evidence for fatness and size to be "included in intersectional [theory, praxis, and] analysis" (Felkins, 2019, p. 184). This will begin to address the erasure of fatness in psychological theories and allow for a new basis of information not based in assimilation into the current oppressive system. These steps towards restorative justice, based in fat liberation, will support the revolution.

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Appendix

Image of Venus of Willendorf

Note. From "The Art of the Ice Age – Exploring the Deeper History of Art" by Bradshaw Foundation, n.d., https://www.bradshawfoundation.com/sculpture/willendorf.php. In the public domain.