Plus-Size Black Women Deserve Respect When Seeking Medical Assistance in the United States

An Analysis of Human Dignity, The Body Neutrality Movement & the Fat Acceptance Movement

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List of Acronyms

ASDAH	Association for Size Diversity and Health
BMI	Body Mass Index
CDA	Critical Discourse Analysis
CDC	Centers of Disease Control and Prevention
HAES	Health at Every Size
IAT	Implicit Association Test
MA	Master of Arts
NAAFA	National Association to Advance Fat Acceptance
NEDA	National Eating Disorder Association
RP	Research Paper
UDHR	Universal Declaration of Human Rights
U.S.	United States

Abstract

Plus-size Black women face an array of systemic socio-institutional discriminations in the United States, including in the medical sector. Being denied or ridiculed when receiving medical care violates the human dignity plus-size Black women deserve. Human dignity is the right to have rights, the right to respect, and non-discrimination due to the intrinsic value of human life. This master thesis will discuss how the Fat Acceptance Movement and the Body Neutrality Movement have the possibility to socially & legally mobilize the human dignity of large Black women seeking medical assistance in the United States. Human dignity is the conceptual framework whilst intersectionality, social movement theory, and "new" social movements are the theoretical frameworks of the thesis. The racist and fatphobic practices within American healthcare are elaborated upon, followed by how these practices hinder plus-size Black women's right to dignity and health. The violation of plus-size Black women's dignity is best described in the case of Barbara Dawson. Then, cases concerning eating disorders and their impact on plus-size Black women are also reviewed. Afterward, a comparison between the social and legal mobilizations of the Fat Acceptance Movement and the Body Neutrality Movement is conducted. To conclude, the historic legal mobilizations of the Fat Acceptance Movement combined with the contemporary social mobilizations of the Body Neutrality Movement have the potential to improve the human dignity of fat Black women demanding appropriate healthcare. This is due to NAAFA's ability to organize successful legal campaigns, and ASDAH's ability to emphasize intersectional and body neutral practices of human dignity that would be beneficial for fat Black women with health issues.

Relevance to Development Studies

The United States has an unsettling history of abusing the human rights of African Americans, including plus-size African American women (BBC Bitesize 2019; Strings 2019). The continued disrespect towards plus-size Black women –especially when the U.S medical sector denies them the right to health and respect– is a prevalent developmental issue occurring in the West that must be addressed. Additionally, this dissertation examines social justice movements, which are a focal point in the Social Justice Perspectives (SJP) major in the MA Development Studies program.

Keywords

Human dignity, social movements, intersectionality, medical discrimination, human rights

Chapter 1: Introduction

If your weight and height equate to a Body Mass Index (BMI) of 25 or over, then you are medically considered overweight. As of 2014, that was the case for more than 70% of the United States population. However, this claim must be taken with a grain of salt, given that the BMI is a medical system founded on racist ideologies that (re)produce misinformation (Nordqvist 2022; Harrison 2018; Firger 2017). Despite the flaws within the BMI system –which will be further discussed in Chapter 4– individuals in larger, racialized, and femme-presenting bodies regularly experience an array of socio-institutional discriminations in the Western world (Harrison 2018; Jouwe 2015; Strings 2019). These individuals have difficulty navigating medical spaces since medical professionals can deny "fat people proper healthcare" due to their size, and make assumptions about someone's health based on their weight (Harrison 2018; Fuller 2021; Lowen 2019). This is particularly apparent in the case of Barbara Dawson, a fifty-seven-year-old plus-size Black woman who requested medical assistance in Florida in late 2015 (White 2017). Barbara Dawson was a plus-size African American woman who suffered extreme pains in her abdomen and had problems breathing. However, Dawson was denied medical services due to a Floridian hospital's inability to diagnose her health problems. The hospital's unwillingness to provide Dawson with medical services led to her early demise (Mollow 2017; White 2017). Barbara Dawson's case will be described in detail in Chapter 4.2.1. Dawson's case reflects how the inconsideration of human dignity in medical spaces can impact the health of women who look like Barbara Dawson, including plus-size Black women with disordered eating. The impact eating disorders have on the human dignity of large African American women will be considered in Chapter 4 as well.

As a result of social and institutional oppression, recipients of this mistreatment can turn to disordered eating, excessive exercise, or substance abuse to cope. These unhealthy habits are also adopted in hopes of receiving respect from a society that aspires to Eurocentric beauty ideals.

Eurocentric beauty standards generally praise European features –which according to Anglo-Saxon Americans and Western media include thinness and a light complexion–deeming fat (Black) people as unattractive, undesirable, and undeserving of attention (Strings 2019; Kessel 2018; Donaghue and Clemitshaw 2012; Yeboah 2020). In addition, larger individuals may become depressed and are more likely to have lower self-esteem (Cowles 2022; Fuller 2021). Consequently, social movements such as the Fat Acceptance Movement, the Body Positivity Movement and the Body Neutrality Movement have emerged to combat these injustices and maintain the human dignity of those affected, including Black people (Fuller 2021; Kase and Mohr 2022). The Body Neutrality Movement and the Fat Acceptance Movement specifically accentuate that no one should ever experience institutional or social discrimination –thus putting their mental and physical health in danger– due to social attitudes towards their body size, the color of their skin, or their gender. The actions taken by both social movements, which are vital components of this dissertation, reveal that the human rights violations intersectional plus-size communities face can be subsided.

1.1 Research Objectives

In this research paper, I will explore how human dignity is threatened by analyzing different understandings of human dignity, and how these understandings are not respected. This problem is particularly noticeable for people in plus-size and racialized bodies who are currently residing in Western countries (Strings 2019). I will also see how both the Body Neutrality Movement and the Fat Acceptance Movement can help mobilize the right to dignity through their previous experiences with social and legal mobilization, alongside how the moral foundations of these movements can help enhance the characteristics of human dignity, especially within the medical sector. That being said, the paper will focus more-so on the Body Neutrality Movement due to the benefits that incorporating body neutrality into American medical arenas could yield. It is also important to underline the dimension of gender alongside other intersections since fatphobia is a

problem that typically targets intersectional identities, including the identities of Black women (Strings 2019). Moreover, this academic research aims to strengthen the relationship between social movements founded on body politics –such as the Body Neutrality Movement and the Fat Acceptance Movement – and human rights through the concept of human dignity. The Body Neutrality Movement and the Fat Acceptance Movement's affiliations with human dignity will be underlined by examining the intersectional discriminations fat Black women have endured when requesting or receiving medical care. Therefore, medical discrimination caused by fatphobic, sexist, and racist ideologies will be the dissertation's primary unit of analysis. Lastly, this thesis aims to stimulate an academic dialogue addressing the human rights issues larger Black women face in an anti-Black, anti-women, and anti-fat society.

1.2 Research Questions

Based on the identified research problem and the objectives, the main research question for this MA thesis paper is: What potential do the Body Neutrality Movement and the Fat Acceptance Movement have, to mobilize the right to human dignity for plus-size Black women in the United States seeking medical assistance?

The sub-questions formulated to support the primary research question are the following:

a. How is human dignity generally understood in human rights and medical contexts?
b. What specifically is the medical sector's approach towards plus-size, feminine, and/or Black bodies with health disparities (including eating disorders)?
c. What are the Fat Acceptance Movement and the Body Neutrality Movement?
d. How can the socio-legal mobilizations of the Fat Acceptance Movement and the Body Neutrality Movement be beneficial for plus-size Black women's human dignity in American medical spaces?

1.3 Relevance and Justification of the Research Topic

In this RP, I will explore human rights, social (in)justice, and intersectionality since these concepts are identified within the Body Neutrality Movement and the Fat Acceptance Movement. Furthermore, analyzing the Fat Acceptance Movement and (especially) the Body Neutrality Movement's contributions to human rights is relevant given that this topic is under-represented in formal human rights discourses. In fact, the idea of human dignity itself allows room for more academic exploration, since the approaches used towards the concept are disputed (Daly and Barak 2021; Düwell 2011; Soltan 2017).

Western beauty standards and institutionalized fatphobia have had harmful impacts on the lives of those who do not conform to these established norms. Not meeting the expectations of American beauty and health norms have put racialized fat women in circumstances that can negatively affect their physical health and/or their mental well-being (Dall'Asen 2021; Harrison 2018; Fuller 2021; Lowen 2019). This is particularly evident for plus-size (Black) women experiencing disordered eating. Chapters 4.3 to 4.5 will concentrate on the mistreatment of plus-size eating disorder patients, considering that there is a glaring gap between this prominent (and intersectional) societal issue and human rights. The abovementioned factors all hinder someone's right to human dignity, especially when being medically treated.

The Body Neutrality Movement and the Fat Acceptance Movement have been selected for this RP since they have the means to mobilize human dignity as a human rights concept and practice. Furthermore, both movements highlight fat perspectives, which tend to be neglected in other social justice movements. Additionally, these two social movements aim to ameliorate the lives of plus-size women (of color) in the United States. To clarify, the United States was selected as the primary geographical focus of this paper due to my Senegalese-American heritage. Therefore, my socio-cultural and institutional understandings of the case studies will be more precise as opposed to other contexts.

1.4 Ethical and Practical Challenges

Ethical and practical challenges are bound to emerge when conducting academic research. Therefore, it is important to address the practical and ethical obstacles that have presented themselves while producing this research paper. In addition, revealing the ethical and practical concerns will help solidify the authenticity and credibility of this MA dissertation. A practical and ethical concern to consider is that this RP almost exclusively used secondary sources for its case studies. Given that most case studies have been formulated by an external source, it is vital to question the reliability of the case studies. Factors that may negatively impact the reliability of a case study include: the academic, legal, social, and cultural contexts in which the case study was created and published; the power dynamics between the individual(s) presenting the case study and the individuals represented in the case study; and the positionality of the publisher(s) of the case study. Thus, it is more difficult to determine if all aspects of the case study are being presented accurately.

Prior to commencing my fieldwork, I expected to implement both case studies and Critical Discourse Analysis (CDA) to add some complexity to my findings and analyses. For the case studies, I aimed to find robust examples that addressed racism, sizeism, and sexism in a legal context. More specifically, I expected to find public legal cases that discussed how the intersectional identities of plus-size Black women were the target of discrimination in American medical spaces, which subsequently prevented them from obtaining medical help. I was also hoping to find extensive examples of socio-legal efforts made by the Body Neutrality Movement and its corresponding organizations, whilst positioning the Fat Acceptance Movement as the foundation of the RP's counterargument. In order for me to conduct CDA, I needed to find relevant manifestos, legal documents, or healthcare policies from various American hospitals that undertook an intersectional focus that emphasized racism, gender, and fatphobia present within the healthcare realm. However, my data collection did not generate the outcomes I had expected.

The Body Neutrality Movement has not had many substantial (socio-)legal campaigns that are open to the public as of November 2022, and it was difficult to find more than one organization that explicitly aligned with this contemporary social justice movement. Furthermore, I found myself intrigued by the Fat Acceptance Movement's legal efforts. Therefore, I decided to analyze both the social and legal mobilizations of the Fat Acceptance Movement and the Body Neutrality Movement to ensure that the RP maintained a human rights angle. The data I collected from my remote fieldwork also consisted of academic journals that discussed the root causes of discriminatory ideologies in medicine, and how these ideologies manifest themselves in the American healthcare system. Furthermore, I was able to find cases that either addressed racism in the American healthcare system or fatphobia in the healthcare system, not both. Thus, intersectional examples were almost impossible to find. The only exception was the case of Barbara Dawson, which will be discussed in Chapter 4.

Conducting my fieldwork revealed the inability to apply Critical Discourse Analysis to this academic paper. This is due to being unable to discover relevant texts that were long enough to apply this discourse analysis method. A contributing factor to this lack of data is how contemporary the Body Neutrality Movement is, given that it was established in 2015 (Cowles 2022). Moreover, the application of CDA would signify repeating contents already mentioned in this paper, taking an approach that would not be relevant to the topic (e.g analyzing specific word choices and their impact), and exceeding the word count of this MA assignment.

Lastly, my positionality must be discussed. Given my personal experiences with fatphobia, racism, and sexism, I am more inclined to be empathetic toward individuals who have experienced the same discrimination as I have. I am also an advocate for the Body Neutrality Movement and the concept of body neutrality, as I believe they are the most realistic alternatives we have (thus far) to ensure the dignity and safety of fat Black women with health concerns. Finally, I support the legal initiatives taken by the Fat Acceptance Movement.

Chapter 2: A Brief History of the Fatphobic, Gender, & Racial Discriminations in American Society, Media, and Medicine

Chapter 1 introduced the RP's research problem, objectives, research questions, relevance, and challenges. To better comprehend the origins of this MA thesis, the historical and societal contexts of American society and medicine must be described. I will be using examples from the medical field, the diet industry, and American media. The explanations of the historical, medical, and societal contexts will illustrate how different sizeist, sexist, and racist stereotypes emerged in American society, and how these stereotypes continue to negatively affect plus-size Black women today.

During the slavery era in the United States, enslaved African women's bodies were given to medical professionals to conduct medical experiments on (Rockich-Winston et.al 2021). Despite slavery's abolition in 1865 (BBC Bitesize 2019), the medical violence continued. One way in which African American women suffered medical violence at the hands of European American doctors is through the mass sterilization of their reproductive organs. The mass sterilization of Black women was carried out due to the U.S government's desire to control African American populations following the eradication of slavery, and due to government-funded hospitals' continued access to poor Black women's bodies (Campbell 2021; Davidson 2018). Thus, the mass sterilizations aptly describe the uneven power dynamic between Black women and white doctors, which has existed for centuries.

The history of inflicting physical pain onto Black women relates to the Black Woman Myth. The myth claims that Black women –and Black people in general– are inherently physically and psychologically stronger than white people. Therefore, Black women experience less pain (Harris 2015, p.90; Mollow 2017, pp.105-106). The Black Woman Myth and its historical context relate to

an argument made by Sara Motta. According to Motta, patriarchal and colonial systems of oppression suggested that women of color's humanity were to be questioned and rejected due to their perceived Otherness and for their failure to satisfy the white male gaze. The dehumanization of the Other continues to create discriminatory experiences for women of color, and consistently undermine their struggles (Motta 2018, p.5). Identifying femme-presenting Black bodies as the dehumanized Other –that white doctors could utilize as medical experiments– is part of the colonial narrative that has justified the violation of larger Black women's human rights to advance the American medical field. Centuries later, Black women's bodies continue to not be seen as human bodies in the American medical sector. Unfortunately, the dehumanization of plus-size Black women (and Black people) was also reflected in American society, especially in mainstream American media.

The 1800s represented a shift in Western beauty standards, considering that the production of mainstream magazines targeted at women began to increase. These magazines included *Ladies Magazine, Godey's Lady's Book*, and *Harper's Bazar*. These three magazines –which contribute to American mainstream media– were established in the U.S to legitimize the imagined community for white, Anglo-Saxon, Protestant women (Strings 2019, pp.122-126). The Anglo-Saxon identity was, and still is, seen as the "racial identity of the United States" (Strings 2019, p.129). Attempts to legitimize this community also required the exclusion of different women, particularly Black women. Other characteristics of this Anglo-Saxon community consisted of the belief of being superior given their white and Christian backgrounds, as well as being more disciplined than white men and women of color. Knowledge about the American Anglo-Saxon community was created and reproduced by popular American magazines at the time, such as *Godey's Lady's Book* (Strings 2019).

Godey's Lady's Book published articles claiming that overeating would hinder one's beauty since it will make Anglo-Saxon American women unwanted, uncultured, less white, and imply their lack

of faith through their lack of self-control (Strings 2019). *Harper's Bazar* supported this misinformation by stating that "African savages" had no self-restraint, hence why they had excess fat and were the inferior race (Strings 2019, p.142). In fact, the magazine's publications compared African women to uncivilized "pigs" with no intrinsic or economic value because of the color of their skin and their weight (Strings 2019, pp.145). Notions of fatphobia continued beyond the 19th century. These inaccurate and harmful assumptions about weight and race have been reproduced by American media and in American public spaces. Examples range from having strangers tell plus-size Black people not to eat because of their weight, to producing films and magazines depicting fat Black bodies as undesirable and offensive (Harrison 2018; Kessel 2018; Strings 2019; Yeboah 2020).

The American media's (re)production of racist and fatphobic discourses has impacted socio-legal culture as well. For instance, Republican congressman Peter Kind stated that " 'had [Eric Garner] not had asthma and a heart condition and was[n't] so obese' " he would still be alive today (Mollow 2017, p.105). Yet, Congressman Kind also claimed that police officers were justified in putting Garner in a chokehold because he was an uncooperative fat Black man who was caught selling counterfeit cigarettes. Behind the racist and fatphobic dialogues, the truth of the matter is that Eric Garner was a large Black man who was murdered due to police brutality and institutionalized racism (Mollow 2017).

Anti-black sentiments have also contributed to the dismissal of Black feminized bodies navigating medical spaces, and these sentiments impact plus-size Black women's abilities to obtain proper medical care (Rockich-Winston et.al 2021, p.239; Campbell 2021). An example is the socio-medical contract and its execution. Although the socio-medical contract –where doctors are expected to heal and protect patients with the utmost professionalism in order for patients to pay for their medical services and to give them social legitimacy– exists, many American doctors do not extend this implicit contract to African American patients. In fact, Black patients receive

poorer healthcare services than white patients. For instance, Black patients who experience the same physical symptoms as white patients are less likely to receive adequate care. In addition, African American women are less likely to have their breast cancer detected than other races in the U.S. (Rockich-Winston et.al 2021; Sakran, Hilton, and Sathya 2020). The implicit socio-medical contract exemplifies how American medical practices have racist undertones that "[favor] white individuals and [legitimize] the mistreatment of those who are nonwhite" (Rockich-Winston et.al 2021, p.238).

The lack of recognition of Black women's human dignity is worsened if they are considered fat. Plus-size Black women are associated with the "chicken-eating Mammy Jezebel [stereotype]," implying that Black women are inactive and lack restraint, thus they are responsible for their poor health (Harris 2015, p.93; Strings 2019). Meaning that when large Black bodies experience health problems, medical professionals should not show them empathy or respect since they supposedly inflicted that suffering onto themselves (Mollow 2017). Summarizing these atrocious historical, medical, and social contexts allows for a deeper understanding of the conceptual framework, theoretical frameworks, and methodology of this research paper.

Chapter 3: Conceptual Framework, Theoretical Frameworks & Methodology

The historical, social, medical, and racial contexts reviewed in Chapter 2 demonstrate how (plus-size) Black people in the United States have been systemically belittled and dehumanized. To better comprehend how the dignity of Black people has been violated, alongside the analyses of this MA thesis, it is essential to explore human dignity as a conceptual framework.

3.1 Conceptual Framework: Human Dignity as a Human Rights Concept

The concept of human dignity began receiving recognition as a human right after World War II through the creation of the Universal Declaration of Human Rights (UDHR). Since then, the right to human dignity (e.g being treated with respect when receiving medical assistance) has been the basis for various constitutions and courts around the world (Düwell 2011, p.218; Daly and Barak 2021, pp.1-2). Although the UDHR is not a legally binding document, the U.S is expected to adhere to the UDHR since they were a core creator of the declaration. Moreover, the UDHR "acts like a global road map for freedom and equality" that every nation-state is expected to follow (Amnesty International 2022). The Universal Declaration of Human Rights addresses human dignity in its preamble as well as in articles 1, 2, 3, 7, 22, 23.3, and 25.1. For instance, article 1 of the UDHR states that "[a]ll human beings are born free and equal in dignity and rights" (United Nations 2020). Furthermore, article 7 strongly implies that one's human dignity should not be impacted by discriminatory practices. The UDHR also suggests that human rights and human dignity are deeply intertwined, along with the notion that human dignity is "the right to have rights" (Düwell 2011, pp.224-225; United Nations 2020). Examples of the right to have rights include the rights to freedom of expression, health, and equality (Daly and Barak 2021, pp.5-6). The Body Neutrality Movement and the Fat Acceptance Movement are currently advocating for these rights.

According to the academic literature identified, human dignity signifies providing and receiving the utmost respect for yourself and others regardless of appearance and background (Düwell 2011, pp.218-227; Soltan 2017, p.365). According to Karol Soltan, human rights spheres understand that human dignity is sacred (Soltan 2017, p.360). Considering that human dignity is sacred, those who suffer from the effects of institutionalized fatphobia, racism, and misogyny must have their human dignity defended as well. This understanding of human dignity will be incorporated throughout the research paper. As previously mentioned, human dignity is applied in legal court cases, and these court cases extend across various generations of human rights. Daly and Barak state that the first generation of human rights issues was concerned about "civil and political rights." Human rights issues tackled by the second generation were about "economic and social rights." Lastly, the third generation was fighting for "solidarity rights" such as "cultural rights" (Daly and Barak 2021, p.2). My RP will subtly address all three generations of human rights by mentioning how the civil and social rights of fat Black women are ignored, and how the social mobilizations of the Fat Acceptance and Body Neutrality Movements aid in reinforcing plus-size individuals' civil, social, and cultural rights.

Although there is an overall understanding of what human dignity implies in the human rights sphere, human dignity is subjective and will be interpreted differently depending on the individual applying it (Daly and Barak 2021, p.5). Likewise, many aspects of human dignity are debated. The primary debate is surrounding the approaches to human dignity. For instance, Andrew Clapham identified four aspects of dignity: 1. banning the mistreatment of all human beings. An example of mistreatment is being condescending towards someone. 2. providing freedom of choice and self-autonomy. 3. protecting an individual's identity also requires protecting the communities they identify with. For instance, their racial community. And lastly, 4. making sure that one has access to their bare necessities, such as having access to medical resources (Clapham in Soltan 2017, p.363). While Clapham's four aspects are a good starting point, Soltan argues that it needs to be reformulated to include more elaborate descriptions of the aspects alongside more factors that

contribute to human dignity, such as the right to education (Soltan 2017, pp.363-367). Soltan has expressed her overall dissatisfaction with the current approaches to human dignity in human rights discourses as well. Furthermore, Soltan believes that human dignity in the human rights field needs to further prioritize its role in achieving justice (specifically social justice) for ostracized groups, not just ostracized individuals. More specifically, Soltan questions the logic behind the human rights approach towards groups of people by saying "[i]f human rights were rights we have by virtue of being human, then groups could not have rights, since groups are not human beings" (Soltan 2017, p.361). Soltan also writes about how in practice there is a disconnect between justice, human rights, and human dignity (Soltan 2017, p.362). This research paper agrees with Clapham's four aspects of dignity. However, the RP will also take on Soltan's criticisms of Clapham's approach by expanding on the characteristics of human dignity (through implementing intersectionality as a theoretical framework) alongside how dignity can be obtained for ostracized communities (through analyzing two social justice movements).

Marcus Düwell criticizes human rights approaches to human dignity as well. He argues that human rights are approaching human dignity under the assumption that human dignity cannot be understood without addressing human rights violations (Düwell 2011, p.216). Likewise, using an inductive approach to human dignity "tend[s] to have a bias towards" individualistic examples of human rights violations rather than examples of collective structural injustices (Düwell 2011, p.217). Therefore, a positivist approach is preferable since it "deal[s] with other-regarding obligations" of human dignity (Düwell 2011, pp.216-220). Although Düwell is justified in investigating the holistic impacts of human dignity violations, this MA dissertation will investigate an array of individual cases to showcase how exactly the human dignity of plus-size Black women seeking medical care is being compromised as a group. This is because fat Black women in the U.S suffer the effects of structural injustices caused by racism, sexism, and sizeism simultaneously. The evaluation of these academic sources demonstrates the fruitful debate emerging from the human

rights sector. Yet, human dignity as a concept goes beyond human rights spheres. In fact, human dignity is tackled in academic medical discourses as well.

3.1.1 Human Dignity in the Medical Field

Human dignity is understood as a broad, multi-faceted, and complicated idea in the medical humanities that has gained traction in academic spaces since the early 2000s (Parandeh et.al 2016; Winter and Winter 2018, p.211). Despite this, some common characteristics of human dignity have been identified. Human dignity in the medical context is about the respect between, within, and amongst humans, especially among patients, nurses, and doctors (Kadivar, Mardani-Hamooleh, and Kouhnavard 2018, p.6). Akram Parandeh and their peers describe human dignity as the ability to have privacy, to have control over one's environment, to be respectful, and to be self-disciplined (Parandeh et.al 2016). This is complemented by Jones, who states that human dignity is about the patients being able to display respect towards themselves by managing the medical circumstances in which they are in, as well as having medical personnel help patients demonstrate their self-dignity (Jones 2015, p.95). Kadivar et.al elaborates on this definition by including the ability to practice and maintain a person's human dignity. They define dignity as "a kind of inner feeling of being good, personal valuation, and self-esteem" (Kadivar, Mardani-Hamooleh, and Kouhnavard 2018, pp.2-5).

The medical humanities practices various forms of human dignity, yet intrinsic human dignity is the most referenced within the academic debate. Intrinsic human dignity explicitly states that; because we are humans, we are all entitled to our humanity, to receive fair treatment, and to be valued in society (Parandeh et.al 2016; Winter and Winter 2018; Jones 2015). An example of practicing intrinsic human dignity is via medical professionals allowing their patients to exercise their universal human rights, such as article 3 of the UDHR which states that "[e]veryone has the right to life, liberty and security" including in medical spaces (Jones 2015; United Nations 2020). The Body Neutrality Movement and the Fat Acceptance Movement affiliate themselves with

intrinsic dignity since they emphasize that a person's entitlement to respect should not be based on their physical attributes. These interpretations of medical human dignity have been accepted, and will be utilized throughout this RP.

There are several approaches taken when discussing and applying human dignity in the medical field. Generally, there are two main approaches to human dignity, the individual approach, and the social approach. On one hand, the individual approach looks at the essence of individuals, and how individuals need to show respect to themselves and others. This approach also looks at "aspects of patient care that acknowledge patients' individuality and integrity, and respect their dignity as human beings throughout the life stages" (Kadivar, Mardani-Hamooleh, and Kouhnavard 2018, p.5). On the other hand, the social approach looks at how dignity depends on socio-cultural interactions (Parandeh et.al 2016; Kadivar, Mardani-Hamooleh, and Kouhnavard 2018, pp.5-6). Some scholars, such as Kadivar et.al, argue that cultural contexts influence the approaches to human dignity in healthcare systems. Jones supports this argument by stating that the characteristics of human dignity are culturally specific. Yet, Jones also states that culture should not dictate whether or not an individual deserves to be treated with dignity (Kadivar, Mardani-Hamooleh, and Kouhnavard 2018, p.8; Jones 2015, pp.92-94). I will briefly inspect how the individual approach is not used to protect the integrity of plus-size Black feminine patients along with how socio-historical contexts are weaponized to deny ill plus-size Black women from recovering from their health issues. The individual approach will be implemented in case studies examined in Chapters 4 and 5. Moreover, this paper will endorse Jones' opinions on the social approach toward human dignity. Specifically, that a patient's background should not determine the respect they receive. It is agreed amongst scholars that human dignity "forms the basis of patient care" and reiterates that patients are not objects, but human subjects who are entitled to integrity regardless of their medical state (Kadivar, Mardani-Hamooleh, and Kouhnavard 2018, pp.5-8).

Although the overall concept is ambiguous, human dignity is significant in medical practices and the medical humanities. Human dignity is essential for providing and receiving adequate medical assistance, creating relevant healthcare policies, and maintaining ethical practices in the medical sector (Parandeh et.al 2016; Winter and Winter 2018; Kadivar, Mardani-Hamooleh, and Kouhnavard 2018). When human dignity is preserved, healthcare providers are more likely to perform better, improve the overall communication within healthcare systems, help the patients feel more valued, and increase the overall trust between and amongst patients and healthcare providers. However, when human dignity is hindered, "feelings of insecurity, guilt, shame, worthlessness, anger, frustration, lack of confidence, inadequacy and reduced motivation" emerge. Additionally, tensions between and amongst patients and medical workers escalate, the professionalism within the healthcare system is diminished, and the human rights of medical patients are jeopardized (Parandeh et.al 2016; Kadivar, Mardani-Hamooleh, and Kouhnavard 2018, pp.2-6). The RP will reveal how human dignity in the medical and human rights contexts can be tarnished, alongside how social movements can preserve the human dignity of large African American women. Furthermore, understanding how human dignity was intended to be applied signifies the possibility to remind human rights and medical professionals of the human dignity fat Black women inherently possess.

3.2 Theoretical Frameworks

Now that the conceptual framework has been defined and explored, it is time to reveal the RP's theoretical frameworks. Intersectionality, social movement theory, and "new" social movements are the theoretical frameworks used in this thesis. Human dignity, alongside these three theoretical frameworks, will be utilized simultaneously to formulate coherent analyses and explain the research paper's conclusions. To specify, the three theoretical frameworks will explain the significance of the human dignity violations large African American women have faced when seeking medical treatment, and what can be done to ameliorate their integrity. The different components of the

RP's case studies were dissected to determine if and how the case studies reflect the characteristics of one or more theoretical frameworks. Creating the associations between the case studies and the theoretical frameworks allows for discussions that question how the human dignity of plus-size Black women is disrespected, along with how the Body Neutrality Movement and the Fat Acceptance Movement can be linked to human dignity in the human rights and medical field.

3.2.1 Intersectionality

Intersectionality was a term established by American lawyer Kimberlé Crenshaw, who wanted to obtain legal justice for Black women facing both racial and gender discrimination in the United States. The term discusses how different aspects of someone's identity (e.g. race, gender, and class) are interconnected and are used to oppress or benefit someone institutionally, socially, or politically. Race, size, and gender will be the aspects of identity that will be analyzed throughout my thesis. Class and cultural identity will be mentioned as well. Intersectionality as a theoretical framework is not only used to identify when this (legally) takes place, but to determine what can be done to counteract injustices. This is not the only advantage of using intersectionality as a theoretical framework. Intersectionality prioritizes the critical analysis of people's lived experience with multifaceted discrimination, which allows for an array of insightful academic revelations (Modiri 2012, p.418; Jouwe 2015).

Intersectionality is a significant theoretical framework to implement in this thesis, for it does not only emerge from the human rights arena, but it directly addresses the human dignity violations experienced by larger Black bodies navigating the Western world. Additionally, the real-life examples from this research paper exemplify how intersectionality is vital for diversifying the understanding of human dignity. The theoretical framework is also important for social justice movements to understand the root issues of their movements and to implement substantial changes. Hence, intersectionality is essential for the overall evolution of human rights as both an academic discipline and as a socio-legal institution.

3.2.2 Social Movement Theory and "New" Social Movements

Social movement theory alongside "new" social movements are the other two theoretical frameworks that have been implemented onto this academic paper. To implement social movement theory, one needs to understand the three aspects of social movement theory. The first aspect requires the comprehension of the circumstances from which the social movement is arising, alongside the opportunities and restrictions present within the movement. The second aspect discusses which social, political, and/or economic structures can be used during a social movement, and how. The third aspect focuses on the individuals following the social movement, and how these supporters affiliate with the movement. Meanwhile, a social movement itself is when a group of individuals mobilize in order to resolve an issue within their social, political, and/or economic structures. Social movements that aim to ameliorate community members' abilities to be treated equally and exercise their rights is called a "new" social movement. Important characteristics of both social movements and "new" social movements are good management and retaining formal political and economic systems (Ballard, Habib, Valodia, and Zuern 2005). "New" social movement as a theoretical framework will be applied to complement social movement theory. Both theories will be employed to analyze the contexts of the Body Neutrality Movement and the Fat Acceptance Movement, as well as evaluate the socio-legal mobilizations taken by the movements in various socio-institutional sectors, such as the medical sector.

3.3 Methodology: Case Study

I have used case studies as the primary method for my master's thesis. Based on my previous experience with this methodology for my bachelor thesis, case studies require the utilization of a specific real-life instance, or multiple real-life instances, which are related to the main topics of the research paper. In this case, that includes real-life examples that address the Body Neutrality Movement, the Fat Acceptance Movement, sexism, racism, sizeism, and/or human dignity as a human rights and medical humanities concept. There are also case studies that focus on the legal

and social mobilizations of organizations affiliated with the Body Neutrality Movement and the Fat Acceptance Movement respectively. Examples of social and legal mobilizations include protests, social media campaigns, and lobbying. I then provide a summary of the specific contexts of the case study or studies (e.g location, parties involved, legal context if it is applicable etc.). The summaries of the case studies' contexts are supported by the contents in Chapter 2, which addressed the overall historical, cultural, and medical circumstances from which the research paper's case studies emerged. Precisely, the historical contexts in Chapter 2 represent the explanations of how plus-size Black women's human dignity has been discarded in the United States of America.

It is vital to mention that the case studies selected for this research paper were found through secondary sources available online, such as academic articles, news articles, and the official websites of organizations, such as the official website of the National Eating Disorder Association (NEDA). Additionally, personal blog posts and statistical data have also been found online as well. These will be considered as primary data. Case studies were collected from different American states. For example, Barbara Dawson's case stems from the state of Florida (White 2017; Mollow 2017). Meanwhile, the statistical information, academic studies, online articles, organizations, and blog posts mentioned in this RP were based (or published) in the states of: North Carolina, Missouri, New York, California, Philadelphia, Las Vegas, Michigan, or an undisclosed location in the United States. Sources published in the United Kingdom and Iran were also incorporated given their relevance to American discourses surrounding fatphobia, racism, sexism, or medical human dignity.

Diction has also been utilized as an implicit methodology in this research paper, specifically the diction surrounding plus-size individuals. The terms big, large, fat, plus-size, overweight, and obese have been consistently used within the Body Neutrality Movement, the Fat Acceptance Movement, and case studies related to the movements (ASDAH 2022b; Snell 2020; Harrison 2018;

Kase and Mohr 2022). Nevertheless, plus-size, fat, and large will be the selected terms used throughout this paper and they will be used interchangeably, similar to how the social movements utilize these terms. However, overweight and obese will not be used since they imply that a person's weight is unacceptable after they reach a certain amount of kilos or pounds, and recreates stigmatizing dialogues. Meanwhile, fat, plus-size, and large will be used purely as descriptors of a certain body type. Of course, these terms are not meant to be offensive. They are simply being used to describe the various bodies that exist (Mollow 2017, p.111), and to reiterate how the social movements want to shift the narrative surrounding plus-size bodies.

Chapter 4: How Discriminatory Medical Approaches Impact the Dignity of Plus-Size Black Women (Barbara Dawson and Eating Disorder Case Studies)

Chapter 3 introduced human dignity, intersectionality, social movement theory, and "new" social movements as conceptual and theoretical frameworks. The previous chapter also revealed that case studies will be the method applied to this academic paper. Chapter 4 will explore how the conceptual framework, methodology, and the theoretical framework of intersectionality resemble when they are being applied onto real-life instances.

4.1 Fatphobic, Sexist and Racist Approaches Towards American Medical Practices

In order to understand how plus-size Black women's dignity is tarnished in real life, the negative stereotypes they experience in medical spaces need to be explained. A notable negative stereotype that plus-size (Black) patients face is exemplified by the usage of the Body Mass Index (BMI). BMI as the main indicator of someone's health is considered to be a given in medical practices, however, the BMI is simply inaccurate. The BMI theorizes that so-called excess weight on a person's body will only cause them to develop "disabilities and [deadly] illnesses" such as "pulmonary embolism[s] […] and a heart condition" (Mollow 2017, p.109). The BMI also presumes that an individual has multiple chronic illnesses if they are in a larger body (Foster 2022). However, the BMI system fails to consider various medical and cultural factors. For instance, the BMI does not distinguish the difference between muscle mass, the weight of bones, and fat (Firger 2017). Similarly, BMI stems from medical studies conducted on individuals of European descent and does not "take into account physiological differences due to ethnicity and race" (Lowen 2019). Thirdly, this medical tool reinforces the assumption that fatness is caused by " 'unhealthy' patterns of eating" due to large Black people's inability to take responsibility for their so-called poor food

choices (Mollow 2017, p.107; Harris 2015, p.93). For example, Eric Garner's racial background and weight were used to legally invalidate his murder, since the grand jury implied that Garner died due to his supposed poor food choices rather than police brutality. In addition, the jury implied that his height-to-weight ratio reflected the stereotype that African Americans have uncontrollable appetites that lead to health problems (Mollow 2017, p.105-107; Strings 2019). Speaking of which, BMI is linked to healthism.

Healthism is the assumption that larger physiques "embod[y] an irresponsible lack of self care; persons (allegedly) displaying such disregard for their own health thus become 'legitimate' targets of social sanction[s]" (Donaghue and Clemitshaw 2012, pp.415-416). However, "the correlation between weight and health is surprisingly weak" because one's weight does not determine the health problems they have, nor their life expectancy. For instance, Black women at larger weights are not expected to have poorer health or shorter life spans. Simultaneously, someone in a smaller body might have significant health issues that go undetected because their BMI indicates that they are in good health (Mollow 2017; Lowen 2019; Foster 2022). Nonetheless, health practitioners are condescending towards plus-size patients and make unfounded "assumptions about health based on [their BMI] figures" (Falk 2021). Thus, U.S medical practitioners assume that a person's BMI is an indicator of their health, despite contemporary studies revealing that this assumption is not medically accurate.

The implicit fatphobia embedded within the BMI system correlates to the weight stigma among American medical professionals. Weight stigma is when discriminatory treatment is harsher for individuals with larger bodies due to their weight, such as when plus-size patients are being processed in the healthcare sector. Weight stigmas can be manifested through interactions between patients and medical professionals. For instance, when a healthcare worker is patronizing a fat patient because of their weight, and kinder to a patient who is not fat (Puhl et.al 2021). In a research study conducted by Puhl and her colleagues in five Western countries including the U.S,

approximately 70% of the American participants experienced "weight stigma from a doctor" once or various times (Puhl et.al 2021, pp.2-7). 24% of the U.S participants avoided healthcare services "even when they suspected they should [see a doctor]" in part due to their weight and feeling distressed when going through physical examinations (Puhl et.al 2021, pp.7-8). Puhl et.al's findings further prove that the United States disregards article 25.1 of the UDHR, which emphasizes the human right to adequate healthcare for all, including fat individuals. Likewise, weight stigmas negatively target the identities of medical patients, which violates article 2 of the UDHR. To clarify, article 2 states that all humans are granted the rights stated in the UDHR (which includes the right to health) regardless of their positionality (United Nations 2020). This 2021 study concludes that weight stigmas, and their dangerous consequences on fat patients, need to be brought to the attention of medical instructors, students, and practitioners. Furthermore, the study encourages healthcare workers to be more conscious of their biases in order to help decrease fat discrimination in healthcare (Puhl et.al 2021, p.14). The conclusions of Puhl et.al's study do not explicitly mention fat Black women. Yet, Puhl et.al's work underlines the importance of implementing body neutrality to guarantee that the human dignity of all medical patients –regardless of their racial backgrounds– is respected.

However, the pursuit of implementing body neutrality in American medical practices will require reforming the beliefs of physicians, especially young physicians. More than half of primary care physicians who participated in another study, published in California, perceived larger patients as unappealing due to their "awkward[ness], unattractive[ness] and non-compliant[ness]." Moreover, the physicians assumed that plus-size patients had no self-discipline (Sabin, Marini, and Nosek 2012, p.1). These perceptions of fat people relate to Sabin et.al's results from their Implicit Association Test (IAT). The IAT showcased that most medical doctors of various genders and body types have a "strong implicit anti-fat bias," though female medical doctors are less likely to have this bias than male doctors (Sabin, Marini, and Nosek 2012, pp.3-5). Implicit fatphobia was prevalent amongst white and Hispanic medical professionals, though physicians from all racial

backgrounds demonstrated internalized anti-fatness (Sabin, Marini, and Nosek 2012, p.4). Subsequently, implicit anti-fat bias harm the "psychological […] and physical health" of plus-size medical patients (Puhl et.al 2021, p.2). The negative effects of anti-fat biases are evident when plus-size Americans build up the courage to go to the doctor's office just for the medical staff to mistreat them, especially fat women patients. In fact, around "53% of overweight and obese women reported receiving inappropriate comments about weight from their doctors" (Sabin, Marini, and Nosek 2012, p.1). Consequently, the cycle of plus-size patients avoiding medical arenas due to weight discrimination continues to persist. (Sabin, Marini, and Nosek 2012).

Looking at these medical findings through an intersectional lens is significant when dissecting the weight discrimination experienced by plus-size women. Because the research participants in Sabin et.al's study are American women, there is a higher expectation for them to meet Eurocentric beauty standards and appeal to the white male gaze. The white male gaze usually does not see plus-size women as desirable or feminine. Therefore, plus-size women are punished for their lack of desirability and the patriarchy's inability to micromanage their bodies (Gerhardt 2020; Donaghue and Clemitshaw 2012, p.415). When plus-size Black women are added to the equation, they experience more severe mistreatment for contrasting whiteness and thinness. It is important to note that although plus-size (Black) women are mistreated for not being desirable to the white male gaze, it does not mean that women who are desirable to these gazes do not experience mistreatment either. Due to not wanting to suffer the consequences of not abiding by restrictive beauty and health norms, plus-size Black women's right to health is hindered. Fat Black women's right to health is at risk since the impact of this medical discrimination leads "to [a] greater internalization of weight bias, which in turn relates to poorer healthcare experiences" (Puhl et.al 2021, p.13). Having healthcare services distributed to patients depending on their alignment with the white male gaze demonstrates how the historical, racial, and medical contexts explained in Chapter 2, unfortunately, apply to present-day violations of human dignity. The institutionalization of fatphobia, sexism, and racism has resulted in the overall decline in adequate healthcare, along

with tense relationships between medical staff and patients. Unequal distribution of healthcare services breaches articles 1, 2, 3, and 25.1 of the UDHR as well (United Nations 2020). Additionally, the decline in the quality of healthcare services depicts the disconnect between the understandings and practices of human dignity in the medical field (Kadivar, Mardani-Hamooleh, and Kouhnavard 2018, p.6).

4.2 How Problematic Medical Approaches Affect Plus-Size Black Women with Health Disparities

Continuing on the topic of weight bias through an intersectional perspective, internalized and externalized weight stigmas within the U.S health sector have damaging impacts on plus-size African American women. The Centers for Disease Control and Prevention (CDC) reported that four-fifths of Black women are fat while also claiming that 57% "of black women are 'obese' " (Mollow 2017). Given that medical and social spaces see being fat as a "disease," the people within these spaces believe that fatness as a disease impacts Black bodies more (Mollow 2017, p.107). Black women are more likely to have their medical needs undermined. The chances of Black women advocating against the medical mismanagement they experience are greater than medical professionals doing their due diligence and ensuring the safety of their patients. When Black women's medical needs are ignored, it leads to their medical exploitation and even their deaths (Campbell 2021, p.47-49). Hence, the United States healthcare system has demonstrated that their endorsement of anti-fat beliefs is "a significant public health concern" for plus-size African American women (Puhl et.al 2021, p.12).

Internalized and externalized weight stigmas also reiterate how (plus-size) Black women in the United States suffer the negative effects of the socio-medical contract mentioned in Chapter 2. Fat Black women are especially at a disadvantage since they are ridiculed before having the opportunity to discuss their health concerns and ask for solutions (Foster 2022; Harris 2015, p.93). The lack of professionalism displayed by doctors mocking their fat Black patients breaches the socio-medical

contract since the contract requires medical staff to be professional while helping their patients with medical concerns (Rockich-Winston et.al 2021). Moreover, the hostile environment created by sizeist, and racist, doctors hinder plus-size African American women's ability to receive medical treatments and improve their dignity. A significant example that demonstrates the inconsideration of fat Black women's human dignity is Barbara Dawson's experience with a Floridian hospital.

4.2.1 The Tragic Case of Barbara Dawson

In December 2015, a plus-size Black woman called Barbara Dawson was rushed to Calhoun Liberty Hospital's emergency room in Florida. She expressed to the hospital's medical staff that she was facing problems with her breathing as well as pain in her abdomen. However, the doctors dismissed her physical pain due to their inability to detect the origins of her health problems. Dawson then acknowledged that her right to health was being compromised by the ER staff since they prohibited her from getting more medical examinations and asked her to leave the hospital's premises. Feeling as if her life was in danger, she strongly advocated for herself so that she would get the medical attention she desperately needed. The medical staff at this Floridian hospital decided to put her life in more danger, rather than protect her, by telephoning the police when Dawson continued to demand treatment (Mollow 2017; White 2017). When Dawson was heading towards the police car after being put into handcuffs against her will, "Dawson collapsed on the ground" due to having a blood clot. Rather than attending to her medical needs, the police officers and staff assumed "that Dawson was fabricating her collapse, deliberately making herself a 'dead weight' to avoid being arrested" and insisted that Dawson will be imprisoned regardless (Mollow 2017, p.108).

When applying the theoretical framework of intersectionality, the lack of medical attention Dawson received, both inside the emergency room and in the hospital's parking lot, demonstrates the dehumanization large Black women continue to encounter. The manner in which the hospital and police staff treated Dawson is linked to the colonial discourse that Black people are not truly

considered humans, since their humanity continues to be debated, even in their most critical moments (Strings 2019; Motta 2018). Additionally, anti-blackness and fatphobia represent "black bodies as unvictimizable by portraying them as excessively strong" since both the police officers and the medical practitioners "were apparently unable to conceive of the possibility that she could truly be suffering" (Mollow 2017, p.108). The un-victimization of Black bodies correlates with the Black Woman Myth, which argues that Black women are incapable of feeling the pain inflicted onto them (Harris 2015).

Due to the medical and police staff's ignorance of her medical emergency, Barbara Dawson lost her life at the age of fifty-seven. The hospital and the police department did not respect Dawson since they did not send condolences, nor did they take the appropriate legal measures to prevent this tragedy from happening again. Instead, they further villainized Barbara Dawson after her death. The coroner's offices claimed that her weight was the cause of her death, not the medical negligence of the medical staff and the police staff (Mollow 2017). The coroner's assessments were supported by federal judge Robert Hinkle, a white man who supported the police officer and the hospital when a wrongful death lawsuit was filed against them (White 2017).

Because Dawson was fat and African American, Judge Hinkle overlooked the violations of Dawson's human rights. Mollow's sentiments regarding Dawson's case reflect the core issues with how Dawson's death was handled. Because of Dawson's intersectional identity, the fat label associated with her identity "create[d] the impression that the real cause of Dawson's death was fatness" (Mollow 2017, p.108). Intersectionality demonstrates that the socio-institutional nuances present when Dawson interacted with healthcare workers and police officers were undermined not only because of Judge Hinkle's inability to empathize with Dawson's lived experiences but also due to the internalized anti-blackness and anti-fatness engraved in American structures. In turn, these oppressive structures prevent Black people in the U.S from receiving respect and obtaining justice.

Moreover, Barbara Dawson's death, and the legal actions taken after her passing, encompass what losing one's human dignity due to sizeism and racism looks like in practice. Dawson's case represents how denouncing the mistreatment of all human beings, one of Clapham's four aspects of human dignity, was violated when Dawson was arrested for wanting medical assistance (Clapham in Soltan 2017, p.363). Concurrently, human dignity in the medical context was disrespected as well. The medical employees at Calhoun Liberty Hospital did not respect Dawson enough to listen to her medical concerns. Additionally, recognizing a medical patient's integrity is an integral characteristic of individual human dignity. However, the Floridian hospital did not consider Dawson's integrity when she, as an African American, was being wrongfully arrested by a police officer (Kadivar, Mardani-Hamooleh, and Kouhnavard 2018, pp.5-6).

Discussing the consequences of weight and racial stigmas, especially through Dawson's tragic story, is vital for demonstrating the various ways in which plus-size Black women's dignity has been violated. Barbara's mistreatment easily makes women who look like her afraid of experiencing the same discrimination when utilizing American healthcare systems, as well as socio-institutional discrimination at large. Consequently, some fat African American women take dangerous measures to avoid racism, sizeism, and sexism. Dangerous practices taken to prevent fatphobic, sexist, and racist discrimination can lead to dire health problems, such as developing an eating disorder.

4.3 The Contexts of Fat African American Women with Eating Disorders

To grasp the impacts of disordered eating on fat African American women, eating disorders within the American setting will be discussed. This will include discussing (some) fat Black women's social, environmental, and economic contexts. These contexts are essential to consider when healing eating disorder patients who are African American women and are considered plus-size.

4.3.1 About Eating Disorders and their Impacts

An eating disorder is a mental illness that disrupts a person's ability to eat healthily and causes emotional distress. There are various types of eating disorders, with the most known ones being anorexia nervosa and bulimia (Oxford Learner's Dictionaries 2022). According to the National Eating Disorder Association (NEDA), around "20 million women and 10 million men will struggle with an eating disorder at some point in their lives" (NEDA 2022a).

Many people develop eating disorders due to societal pressures to lose weight or to have physical features deemed desirable by (Western) society. When an eating disorder patient is limiting their food intake, for instance, they may experience short-term weight loss, yet their body then realizes that it is being starved. Thus, eating disorder sufferers may have binge eating episodes, and/or will begin to (re-)gain weight as their bodies attempt to save their lives. Dieting does not only negatively affect one's body physically, but it is also linked to depression, anxiety, and increases the chances of developing signs of (other) eating disorders (Foster 2022; Mollow 2017; Falk 2021; Milner 2021). Eating disorders are the deadliest psychological illness since the pursuit of the so-called perfect body has dangerous physical effects such as "purging, starvation, and over-exercise," which can lead to "heart attack[s], kidney failure, osteoporosis, and electrolyte imbalance." If someone is unable to obtain the body ideal they have created in their heads or the beauty expectations set by their society, the psychological effects of an eating disorder may urge them to take their own lives (NEDA 2022a).

It is crucial to note that eating disorders do not discriminate. Disordered eating can affect anyone regardless of their racial or cultural background, gender, age, size, religion, and sexual orientation, not just thin white women in the West. Plus-size Black individuals can suffer from eating disorders (NEDA 2022c; Muhlheim 2021; Milner 2021). However, there is a lack of recognition for plus-size and Black eating disorder sufferers in society, including in the medical field. As Muhlheim writes, "[r]ecovering from an eating disorder in a world dominated by diet

culture is hard enough. It is even harder if you are in a larger body or gain weight and develop a larger body as part of recovery, and must deal with the impact of weight stigma" (Muhlheim 2021).

4.3.2 The Environmental, Social, and Economic Contexts of Plus-Size and Black Eating Disorder Patients

Environmental and economic racism is prominent in the United States given that the country has created food deserts in predominantly (poor) African American communities in order to limit their access to nutritious produce. Subsequently, food deserts lead to African Americans not meeting the nutritional intake needed to live a healthy life. Furthermore, access to nutritious foods is more expensive and time-consuming to create, which could be detrimental for low-income African American households with minimal social support (Mollow 2017, p.108; Harris 2015, p.93). Acknowledging environmental racism reinforces the urgency to apply intersectional approaches to healthcare for large Black patients suffering from eating disorders. This environmental and economic context may exacerbate the eating disorders of plus-size Black patients, given their accessibility to unhealthy foods and then feeling guilty once they have consumed such foods. The inability to avoid trigger foods, therefore, makes it more difficult for these eating disorders patients to recover.

Unfortunately, food deserts are not the only tools used to enforce institutionalized racism and fatphobia targeting African American demographics. For instance, putting fat (Black) eating disorder patients on calorie-deficit regimens despite treating them for anorexia (Muhlheim 2021) is dangerous and arguably originates from colonial ideologies. Specifically, the colonial ideology that fatphobia can be used "against the non-being and dehumanization of the colonized Other" by making African Americans assimilate to whiteness through thinness. Thinness is presented under the pretense that weight loss will physically improve a fat person's body, and that being thin is essential for a high quality of living (Motta 2018; Donaghue and Clemitshaw 2012). These colonial sentiments reflect the practice of doctors blaming their feminized and racialized patients

for being "indocile [and] undisciplined" rather than looking at the medical conditions hindering the patient's health (Ureña 2019, p.1648; Falk 2021).

"Diet corporations aggressively target communities of color, using advertising campaigns that feature African American celebrities" to boost their financial profits and to reaffirm the American idea that one needs to be closer to white femininity by losing weight (Mollow 2017, p.110; Foster 2022). Moreover, the false assumptions that weight loss will lead to better health and overall happiness is caused by "the financial power of the diet industry," which is worth "over sixty billion dollars in the U. S. alone," and financially provide for "most of the scientific studies purporting to show that fatness poses health risks" (Donaghue and Clemitshaw 2012; Mollow 2017, p.110; Gerhardt 2020). The initiatives of diet corporations are problematic considering that some Black women are genetically unable to maintain a low body weight healthily and sustainably, given that their bodies operate better at higher body weights (Mollow 2017, p.110; Lowen 2019).

Despite research indicating that Black women can be healthier at larger sizes, large Black women are still made to feel uncomfortable for not conforming to thin white beauty standards. Consequently, fat Black women feel obliged to diet. Black women diet to not only acknowledge their juxtaposition to whiteness but to demonstrate that they are taking actions to counteract that through assimilation. Additionally, diet culture is used to socially connect with other women, since they relate to feeling the pressures to succumb to white patriarchal systems obsessed with controlling women's bodies and behaviors (Foster 2022; Gerhardt 2020). Black women also feel pressures to not only meet European American interpretations of beauty –especially when living in predominantly white areas– but to meet African American interpretations of beauty as well. Having an hourglass figure –which consists of a large bust, a small waist, and large hips– is viewed as the ideal body type amongst many Black communities. Being compared to African American alongside European American standards of beauty can be overwhelming and harmful to one's self-confidence (Allen 2022; Milner 2021; Harris 2015; Foster 2022).

The societal pressures fat Black women experience to look thin, alongside the practices they feel forced to conduct in order to achieve thinness, infringe on their medical human dignity. Being bombarded with anti-fat and anti-Black messaging in social and institutional environments makes it almost impossible for plus-size Black women to feel inner joy and self-worth (Kadivar, Mardani-Hamooleh, and Kouhnavard 2018). Diet corporations are exploiting the colonial wounds inflicted onto African American women for not aligning with the feminine identity of Anglo-Saxon immigrants (Motta 2018; Strings 2019). When these colonial injuries lead to disordered eating, it is the responsibility of medical professionals to help heal the physical effects of these colonial wounds. However, medical practices, including in the field of disordered eating, continue to perpetuate colonial injuries by enforcing fatphobic procedures.

4.4 How the Flaws Within Eating Disorder Recovery Programs Harm Plus-Size (Black) Women

Generally, plus-size individuals who develop disordered eating have their struggles undermined by medical professionals. Moreover, their disordered eating is celebrated amongst their social circles due to the illusion that fat people do not struggle with disordered eating, and that they should aim to become slimmer. When a plus-size person with an eating disorder decides to take initiative towards healing, they "often receive mixed messages that can ultimately make it harder to recover. They may be encouraged to restrict their eating in ways that contradict behaviors required for recovery" (Muhlheim 2021).

Erin Harrop's experience is a testament to these problematic approaches toward medical treatment. Harrop, a fat eating disorder researcher who also suffered from anorexia for 20 years, expected to receive "a weight-restoration or weight-stabilization meal plan," similar to the plans her peers in smaller bodies had received when they all began treatment (Harrop 2018, p.51; Muhlheim 2021). However, she was medically encouraged to continue her eating disorder by following a meal plan that would put her in a calorie deficit, and was encouraged to not finish her

meals as well. Furthermore, her therapist during treatment dismissed her struggles with anorexia as other health problems, such as substance abuse, due to Harrop's weight not aligning with the typical weight of anorexia patients (Harrop 2018). Consequently, Harrop's medical human dignity was tarnished due to fatphobic ideologies and fatphobic medical practices that did not prioritize Harrop's well-being and right to good health. That was reflected through her low self-esteem and feelings of isolation due to her weight. The feelings of isolation were amplified by thinner patients bullying her and medical staff discrediting her struggles with anorexia (Muhlheim 2021; Harrop 2018). This isolation led to Harrop feeling dehumanized because their illness was invalidated and disrespected (Kadivar, Mardani-Hamooleh, and Kouhnavard 2018). In addition, the mistreatment Harrop endured impacted the other anorexic patients since it reinforced the idea that weight gain was to be feared, which confirmed that their disordered eating habits were justified (Muhlheim 2021). Harrop's experience with fatphobic medical professionals is not an isolated incident. Shira Rosenblith, another plus-size woman recovering from an eating disorder, stated that "she was praised by a doctor for not eating during one of her inpatient treatment stays" (Muhlheim 2021).

Both Harrop and Rosenblith's experiences are heartbreaking, and they also showcase how "[t]he lack of support for recovery as a larger person may leave them vulnerable to pressures to diet and relapse" after completing their recovery treatments, given that their physiques do not match the stereotypical physiques of recovered eating disorders sufferers (Muhlheim 2021). The inappropriate approach towards plus-size eating disorder patients is an institutional problem since medical experts in disordered eating have been given curriculums that state that plus-size patients were to blame for their health problems, and that weight loss is the cause of improved health. This clearly shows that using weight loss as an indicator of good health displays the incompetence of many medical curriculums, as well as the lack of holistic and reliable research conducted by many medical professionals (Falk 2021; Foster 2022).

Two conclusions can be deduced from the Harrop case study alongside the Rosenblith example. The first conclusion is that Harrop and Rosenblith's testimonies highlight the need to reform medical discourses to incorporate body neutral narratives as well as medical narratives that emphasize human dignity. Body neutral narratives that could be enforced include encouraging patients to appreciate their character along with promoting a healthy relationship between a patient and their bodies through physical activities that bring them joy (Cowles 2022). The medical field's attitude towards human dignity is applicable as well, through the consistent practice of intrinsic human dignity inside and beyond medical spaces (Parandeh et.al 2016; Winter and Winter 2018; Jones 2015). Furthermore, the individual approach of medical human dignity was not applied to Harrop's case, since the medical staff did not consider Harrop's personal case of experiencing anorexia in a larger body (Kadivar, Mardani-Hamooleh, and Kouhnavard 2018). These medical changes are necessary because no medical patients should leave a treatment feeling anxious, depressed, or feeling as if their physical and psychological conditions have worsened.

When analyzing these cases, it is critical to note that both Harrop and Rosenblith are white women. When looking at their unfortunate experiences from an intersectional perspective, it is clear that the discrimination they faced would be worse if they were Black. Given the information provided in previous chapters, the historical dehumanization of Black women in the U.S medical field, combined with the anti-fat biases prominent amongst medical professionals, would make it more difficult for Black women (regardless of their weight) to have their medical difficulties taken seriously. Therefore, the second conclusion is that the regimen for Black, feminized, and/or plus-size eating disorder patients is problematic since it prioritizes anti-fat ideologies instead of health. In addition, plus-size Black women's struggles with eating disorders are belittled because there is hardly any representation of their struggles in medical spaces. The incohesive eating disorder treatments, along with the little acknowledgment for fat Black eating disorder patients, are traumatic for the recovering patients. In turn, their rights to adequate health, quality of life, and receiving dignity are violated.

4.5 The Problematic Insurance Policies for Eating Disorder Recoverees

Recovery for plus-size eating disorder patients is further diminished due to fatphobic insurance policies. When an eating disorder patient wants to receive health insurance, they need a healthcare provider to create a case for the insurance company on their behalf. The case then goes to case managers, who determine whether a medical patient will or will not receive health plan benefits, and if they do, they determine which benefits they obtain. Yet, most case managers have no professional understanding of eating disorders and the intricacies that accompany them. Though, the NEDA website implies that case managers tend to have a broad background in health. Healthcare providers and patients tend to strongly advocate for their insurance claims to be accepted, though it is very difficult to convince the case managers (NEDA 2022b; Muhlheim 2021). The case manager's lack of awareness regarding disordered eating is dangerous. If the case manager has anti-fat, anti-Black, and/or misogynistic biases, then their views can prevent them from providing an eating disorder patient with the financial support they desperately need. Therefore, increasing the chances of ignoring the human dignity of eating disorder patients. Their integrity is further ignored if case managers do not comprehend how difficult life could physically and psychologically be when having an eating disorder, while simultaneously experiencing racism and sizeism.

Common reasons to deny eating disorder patients' insurance benefits are due to them not fitting the so-called stereotypical weight of eating disorder patients. Thus, sufferers of eating disorders must have a very low body weight for their struggles to be medically recognized. Insurance companies can also deny providing health plan benefits if eating disorder patients do not experience any "medical complications" (NEDA 2022b). Kidney failure and cardiac arrest are examples of medical complications that are caused by eating disorders and are acknowledged by insurance companies (NEDA 2022a). Additionally, some insurance companies do not acknowledge how the psychological and physical dimensions of eating disorders intersect. Thus,

limiting patients to either select physical healthcare benefits or psychological healthcare benefits. At times, patients may need to contact various insurance companies to have their healthcare covered, which in turn complicates the insurance process for patients and causes anxiety (NEDA 2022b).

The insurance policies for eating disorder patients are extremely problematic, considering that one's weight does not determine a patient's health, nor does it determine if someone is suffering from an eating disorder. Furthermore, human dignity in the human rights and medical contexts is infringed upon. The medical sector emphasizes intrinsic human dignity regardless of a healthcare worker's socio-cultural perceptions of a patient. However, the insurance policies mentioned above indicate that intrinsic human dignity does not apply to plus-size (Black) eating disorder sufferers, given that their fatness makes them unqualifiable candidates for eating disorder healthcare benefits (Jones 2015; NEDA 2022b). Meanwhile, the human rights sphere condemns restricting people from meeting their essential needs alongside restricting people's freedoms, especially when it concerns their well-being (Clapham in Soltan 2017, p.363; United Nations 2020). Additional human dignity violations could be detected when implementing an intersectional lens onto these insurance policies. Given the dehumanization of Black people throughout American history – accompanied by the misconceived notion that only middle-upper class white women experience eating disorders (Milner 2021)– plus-size Black women can be denied medical care due to the misconception that plus-size women and/or Black women are incapable of having eating disorders due to their identity and their weight. Class also plays a role in this example. Some plus-size Black people may not have the medical funds to determine whether they are experiencing medical complications, and their medical symptoms can be undermined due to the medical sector's history of delegitimizing Black women's sufferings.

In conclusion, Chapter 4 addresses how the discriminatory approaches toward American medical practices negatively affect the physical and mental well-being of plus-size Black women

patients, especially since medical professionals tend to have anti-fat and anti-Black biases. This is depicted through the death of Barbara Dawson, who died from medical negligence rooted in medical racism, medical sexism, and medical fatphobia. The U.S healthcare system also puts a physical and psychological damper on fat women with eating disorders since their struggles with eating disorders are belittled. Additionally, health insurance policies worsen fat (Black) women's dignity since the requirements to receive healthcare benefits disregard the fact that fat people can have eating disorders, and that Black people can have their medical needs overlooked due to their race. Fortunately, there are social justice movements aimed at improving the human and medical rights of fat (Black) people.

Chapter 5: The Legal and Social Mobilizations of the Body Neutrality Movement & the Fat Acceptance Movement

Chapter 4 provided a real-life and detailed picture of how plus-size Black women's human dignity was lost when seeking medical assistance in the United States. The violations of human dignity in practice were best reflected through the lived experiences of Barbara Dawson, alongside an intersectional take on Erin Harrop and Shira Rosenblith's experiences when recovering from disordered eating. Given the contents of Chapter 4, Chapter 5 will proceed to discuss how the social and legal mobilizations of the Body Neutrality Movement and the Fat Acceptance Movement have the potential to ameliorate plus-size Black women's human dignity in the American medical sector. To better appreciate what each movement brings to the table, their histories must be told.

5.1 The Evolutions of the Fat Acceptance Movement and the Body Neutrality Movement

The Fat Acceptance Movement emerged in the United States during the 1960s. The goal of the social justice movement was "to combat the pervasive stigmatization of fat individuals and improve their quality of life" and to no longer have fat people endure discrimination and social torment due to not meeting thin beauty standards (Kase and Mohr 2022; Fuller 2021). The roots of the movement are intersectional since they strongly aligned themselves with the Second Wave of Feminism (especially the queer members of the movement) and were inspired by the Black Power ideology that was taking center stage at the time (Gerhardt 2020; Foster 2022; Kase and Mohr 2022). The Fat Acceptance Movement has attempted to implement intersectionality since it has acknowledged that fatphobia can be worsened by "other forms of oppression" such as ableism, racism, homophobia, and classism. The developments within the Fat Acceptance Movement became the stepping stones for the Body Positivity Movement (Kase and Mohr 2022; Fuller 2021).

The Body Positivity Movement gained momentum online in 2012. The movement's goal was to defy unattainable standards of beauty for women, endorse self-love and acceptance, and obtain more "human rights for bigger bodies" (Fuller 2021; Kessel 2018). Although the social movement's message to promote diversity and self-love was largely successful in the fashion industry, in traditional media, and (especially) on social media, the flaws of the movement were apparent (Yeboah 2020). Firstly, the movement drowned the voices of its founders. Although the faces of the Body Positivity Movement were "women of [color], women with disabilities and transwomen," the new spokespersons are now white women who fit Western beauty ideals and are "no bigger than a size 16" (Kessel 2018). This shift in representation has made the original audience of the movement feel excluded (Yeboah 2020). Moreover, the expectations of the movement are considered more unattainable. The idea of constantly loving one's body can make an individual hyperfocus on their appearance and subsequently partake in unhealthy habits to accelerate their journey with self-acceptance. The Body Positivity Movement also promotes the fallacy that one can only love themselves if they are physically attractive, and that one should consistently love their appearance (Kessel 2018; Fuller 2021).

The criticisms from the Body Positivity Movement led to the formation of the Body Neutrality Movement in 2015 (Cowles 2022). The Body Neutrality Movement began receiving more attention due to Anne Poirier's incorporation of the movement in her food counselling workshops, body image coaching sessions, and in her book *The Body Joyful* (Cowles 2022; Dall'Asen 2021). The concept of body neutrality is defined as "taking a neutral perspective towards your body, meaning that you do not have to cultivate a love for your body or feel that you have to love your body every day" (Fuller 2021). The definition of body neutrality sets the foundation of the Body Neutrality Movement. This intersectional social movement aims to help individuals "find peace" within themselves in terms of their physical appearance and abilities (Kessel 2018). One could find peace by practicing "mindfulness" and respecting one's body by "giv[ing] it care, nutrition, rest, and movement" (Fuller 2021; Cowles 2022). The social justice movement also encourages people to

appreciate their bodies' capabilities in order to decrease their feelings of self-hatred and betrayal (Cowles 2022; Kessel 2018). This could be accomplished through praising aspects of one's "mental and emotional" identities, alongside embracing physical changes as they occur (Dall'Asen 2021; Cowles 2022). Marginalized bodies, including larger bodies and people with disabilities, have been supporters of this movement. When interpreting the Body Neutrality Movement beyond the personal level, the movement arguably aims to facilitate the removal of socio-political stigmas connected to fat racialized bodies existing in Western societies.

The Fat Acceptance Movement was chosen over the Body Positivity Movement for this research paper. Fat activists from the National Association to Advance Fat Acceptance (NAAFA) demonstrate how the Fat Acceptance Movement takes a more political stance than the Body Positivity Movement. The Fat Acceptance Movement's main goal is to increase the human rights available to plus-size people, for instance, having their rights supported when using healthcare systems (Foster 2022; Tovar 2019; Gerhardt 2020). The practical flaws of the Body Positivity Movement, as previously mentioned, are the reasons why the Body Neutrality Movement has also been selected as a focal social movement for this dissertation. Moreover, the Body Neutrality Movement and its accompanying practice of Health at Every Size (which will be explored in section 5.3) have roots in fat, queer, and feminist activisms (Gerhardt 2020). This context enables us to appreciate how the Fat Acceptance Movement and the Body Neutrality Movement are interconnected. The paradigm shift created by the Body Neutrality Movement embodies the functions of social justice movements, while the Fat Acceptance Movement demonstrates the impacts social justice movements can have when legal advocacy is prevalent. Thus, the Fat Acceptance Movement and the Body Neutrality Movement complement each other in that regard. These movements' ability to complement each other, and their shared history, are also reasons as to why they have been selected for my research paper.

5.2 The Legal Mobilizations of the Fat Acceptance Movement and the Body Neutrality Movement

Given the contextualization provided in section 5.1, this upcoming section of the RP will discuss the legal initiatives taken by the Body Neutrality Movement and the Fat Acceptance Movement, alongside their potential to help the human dignity of plus-size Black women seeking healthcare. Let us first discuss the legal mobilization efforts of the Body Neutrality Movement. The Association for Size Diversity and Health (ASDAH) –an organization that aligns with the Body Neutrality Movement– shares socio-legal mobilization tools on their official website through "education and resources that dismantle weight-centered health policies and practices and that promote the Health at Every Size [...] Principles [...] in health" (ASDAH 2022c). As of November 2022, ASDAH is on the verge of publicly launching its Abolish BMI Coalition in collaboration with NAAFA, which will tackle both the fatphobic and racist practices embedded in American healthcare. In the meantime, ASDAH continues to raise funds for their organization, encourage silent supporters of the organization to join the movement, and hold conferences aimed at tackling anti-fatness in the medical arena (ASDAH 2022c). ASDAH also contributes towards "health policies that improve and equalize access to information and services, and personal practices that improve human well-being, including attention to individual physical, economic, social, spiritual, emotional and other needs" (ASDAH 2022b). Though it must be noted that the information published by ASDAH does not go into much detail about their legal initiatives.

ASDAH reflects how the Body Neutrality Movement is a "new" social movement since ASDAH has displayed their ability to organize their association in a way that is accessible to their supporters. Furthermore, ASDAH is using official institutional and legal systems, such as health policies, to advocate for body neutrality and for the human rights that the Body Neutrality Movement helps bring to the forefront. Elements of social movement theory are also identifiable

in ASDAH's initiatives. For instance, the second element of social movement theory is portrayed through using economic structures such as fundraisers to fund the Body Neutrality Movement's ambitions. Socio-political structures are being utilized as well, as seen through the organization of conferences aimed at combating the American healthcare system's fat prejudice (Ballard, Habib, Valodia, and Zuern 2005). However, the lack of transparency regarding their legal advocacy makes the Body Neutrality Movement currently less reliable to enact legal changes that would protect the human dignity of fat African American women seeking medical care. Fortunately, NAAFA compensates for ASDAH's lack of public legal activity.

The Fat Acceptance Movement has more notable examples of legal mobilization –especially through NAAFA's efforts– which shows its potential to improve the human dignity of plus-size Black women in the U.S. Evidence of the movement's ability to legally mobilize can be traced back to 1967. The Fat Acceptance Movement organized fat-ins –similar to the sit-ins organized by African Americans during the Civil Rights Movement– in New York's Central Park. The 500 attendees of the protest "carried signs of protest, burned diet books and photos of model Twiggy, and were [...] [loud]" to raise awareness of anti-fat biases present in mainstream American culture (Gerhardt 2020). The Fat Acceptance Movement's determination to establish legal, social, and institutional change continued into the 1970s. The movement organized "letter-writing campaigns and provid[ed] a social network for its members," alongside conferences aimed to strengthen the movement's community (Gerhardt 2020).

The mobilization examples from the 1960s and 1970s reflect both the first and second aspects of social movement theory since the Fat Acceptance Movement understood how to benefit from the opportunities available. Given the success of sit-ins and protest signs during the Civil Rights Movement, along with feminist protests in the 1970s (BBC Bitesize 2019; Gerhardt 2020), the Fat Acceptance Movement knew how to maximize the structures of these socio-political events to their advantage, hence the success of their fat-ins at Central Park. Similarly, organizing conferences

to solidify the bond amongst Fat Acceptance activists displays elements of the third aspect of social movement theory, considering that the activities organized during the conferences (e.g. dances and networking events) strengthened the supporter's affiliation, and therefore their support, towards the social justice movement and their corresponding protests (Gerhardt 2020; Ballard, Habib, Valodia, and Zuern 2005).

The Fat Acceptance Movement's approaches to legal mobilization shifted during the 21st century for there was a stronger emphasis on online spaces. NAAFA states on their website that they take pride in being a political organization that aims to improve the human rights of fat individuals in various societal sectors, such as the healthcare sector (Gerhardt 2020). NAAFA accomplishes this through social media campaigns alongside informing their supporters about the legal tools available so that they can advocate for themselves. Additionally, NAAFA invites their supporters to recount their struggles with fatphobia and to share their struggles with the organization and pro-NAAFA state senators. The organization also provides links to how to access state senators, information regarding the pro-fat acceptance policies, and the organization's relevant contact information. NAAFA participates in lobbying with U.S senators as well. Furthermore, NAAFA has a web page titled #EqualityAtEverySize, where Fat Acceptance supporters can complete a form to show their support for "adding weight anti-discrimination laws [targeting fat people] where [the supporters] reside." #EqualityAtEverySize also allows supporters to collaborate with NAAFA on social and legal campaigns in the region the supporter resides in (Howell et.al 2022).

NAAFA's approaches toward legal mobilizations highlight the organization's ability to maximize the functions of the United States' political and legal systems. Additionally, NAAFA depicts which acts of protest can be utilized to improve the human rights of (Black) plus-size people in the U.S so that they can be fairly treated in communal spaces like hospitals. This is illustrated through their lobbying work with U.S senators and encouraging their supporters to

interact politically to instill legal reform. Furthermore, NAAFA organizes its socio-legal mobilization tools efficiently on their website and clearly demonstrates their aim to congregate in an effective and supportive manner, thus solidifying the connections between the Fat Acceptance Movement and its advocates. Therefore, NAAFA exemplifies how "new" social movements, and the three aspects of social movement theory, can operate effectively (Ballard, Habib, Valodia, and Zuern 2005). The second dimension of social movement theory is evident in the examples presented. The Fat Acceptance Movement is aware that using social systems such as the internet can further spread their message to dismantle fatphobic structures and offer them the socio-institutional tools that would lead to substantial legal changes, such as using the official website to promote their #EqualityAtEverySize operation.

To conclude, the legal mobilizations of the Fat Acceptance Movement and the Body Neutrality Movement can be beneficial for plus-size Black women's human dignity in American medical spaces via NAAFA's legal efforts. NAAFA currently has more remarkable examples of legal mobilization than ASDAH, though ASDAH has expressed interest in taking public legal actions. NAAFA's history of legal mobilization shows the Fat Acceptance Movement's potential to improve the human dignity of plus-size Black women in the U.S. This is because NAAFA can use the legal tools they have accumulated since the 1960s to effectively advocate for the dignity of plus-size (Black) patients requesting medical attention, especially since the dignity of fat people is at the core of the social movement.

5.3 The Social Mobilizations of the Fat Acceptance Movement and the Body Neutrality Movement

Though NAAFA has leverage over ASDAH regarding legal mobilizations, the Fat Acceptance Movement finds itself at a disadvantage when it comes to social mobilizations in comparison with the Body Neutrality Movement. This is first displayed through the context in which the Fat

Acceptance Movement stemmed from. The Fat Acceptance Movement was formed in the late 1960s, which is parallel to the time the Second Wave of Feminism was in full force (Gerhardt 2020). Although the movement is intersectional in the feminist sense, it takes a very Eurocentric approach to feminism that is appealing to middle-class white women but not to many Black women of any socio-economic class. This is because the second feminist wave was created by white American housewives who belonged to the middle-upper classes. Additionally, white middle-upper-class women became the face of the feminist movement, and they publicly excluded Black women when mobilizing against the patriarchy. The Second Wave of Feminism also undermined how race and gender can play a role in someone's oppression, especially when seeking medical attention (Grady 2018). How the Second Wave of Feminism led to the exclusivity of the Fat Acceptance Movement is best described by Donaghue and Clemitshaw. "[A]lthough issues of intersectionality and privilege in [Fat Acceptance] are frequently raised within the movement, the public face of the [Fat Acceptance] movement remains predominantly white, middle class, and highly educated" (Donaghue and Clemitshaw 2012, p.417). The intersectional criticisms are reiterated through the flaws within the Fatosphere.

The Fatosphere is an online forum created by fat activists in 2007. Participants shared their journeys with fat acceptance and its accompanying movement. The Fatosphere also discussed how to combat anti-fat discourses in American social atmospheres and used the website as a place to discuss socio-legal initiatives that can be taken to help fat people utilizing healthcare (Donaghue and Clemitshaw 2012). Therefore, the Fatosphere had socio-legal potential since the forum combined the personal with the political. However, the Fatosphere represents the Fat Acceptance Movement's failure to be inclusive and intersectional. The primary criticism of the Fatosphere is that the online forum is ultimately an online space created by young, white, educated, middle-class women, for young, white, educated, middle-class women. Thus, the voices of plus-size Black women on a social justice issue that strongly affects them –which includes discriminatory medical practices– continue to fade (Donaghue and Clemitshaw 2012). From an intersectional perspective,

plus-size Black women from all social classes are more likely to have their struggles downplayed due to middle-class white women's inability to fully comprehend the extent to which institutionalized racism operates, especially when discussing negative experiences with the American healthcare system. This of course does not mean that white women cannot empathize with communities of color. Nonetheless, it would be more difficult for plus-size Black women to receive justice in the healthcare system if intersectionality is not understood amongst the members of a social movement related to their injustices.

Furthermore, the Fatosphere depicts how the Fat Acceptance Movement continues to struggle with accepting their fatness since many members of the Fatosphere find the idea of being thin an incredibly attractive idea. This implies "that the best that fat people can hope for is acceptance (rather than celebration) of their bodies" which reproduces the notion that thinness is the ideal in the U.S (Donaghue and Clemitshaw 2012, p.423). The inability to personally support the message of a social justice movement will inherently make institutional changes, including in healthcare, more difficult to accomplish. This desire to be thin demonstrates how; although there have been legal initiatives taken to protect fat people's rights, the desire to be thin makes the social foundation of this social movement fragile. When applying intersectionality, the pursuit of thinness is closer to the white American beauty ideal (Harris 2019; Donaghue and Clemitshaw 2012), which emphasizes the lack of intersectional practices in the Fat Acceptance Movement.

Fortunately, the Body Neutrality Movement allows for a more nuanced interpretation of our appearances and makes a distinction between the way your body looks and the way your body feels (Fuller 2021; Kessel 2018). Incorporating intersectional body neutral discourses into the U.S healthcare systems was the primary discussion at ASDAH's June 2022 Conference. The conference created a space for Black plus-size activists, such as Imani Barbarin and Sabrina Strings, to discover how intersectional forms of medical and social discrimination need to be discussed and dismantled in academic spaces (ASDAH 2022a).

Another significant social initiative taken by ASDAH is the creation of the Health at Every Size (HAES) principles. HAES, which strongly aligns with the Body Neutrality Movement, is a health principle that advocates for a weight-neutral approach towards health since an individual's physique does not determine their health. HAES also believes in treating all patients with the appropriate medical attention regardless of their weight, and that problematic medical tools such as BMI should be demolished (Falk 2021; ASDAH 2022b). The health principle is commonly used by medical practitioners who specialize in healing eating disorders and aim to take a "weight-neutral approach to healthcare," including for plus-size eating disorder patients (Gerhardt 2020). For example, medical professionals who implement HAES prioritize the body's intuition with food and exercise. Likewise, they encourage patients to conduct life practices that allow their bodies to communicate their needs. For example, expanding on the types of foods patients can eat rather than eliminating foods; encouraging patients to do physical movements that they enjoy rather than physical movements that will lead to weight loss and anxious thoughts; along with improving the patient's sleep quality. HAES practitioners also promote body neutrality, since they invite their eating disorder patients to accept fluctuations in their weight as they recover (ASDAH 2022b; Falk 2021)

The use of HAES exemplifies how the Body Neutrality Movement prioritizes the human dignity of those seeking medical attention, which signifies improving plus-size Black women's access to their human rights. Specifically, HAES touches on the UDHR articles that mention the right to life, the right to a good quality of life, the right to equal treatment (regardless of gender or race), and the right to health (United Nations 2020). The Body Neutrality Movement's alignment with the UDHR is demonstrated through HAES' approach towards exercise and food. ASDAH is aware that if they do not take this weight-neutral approach towards medical patients, especially ones with eating disorders, then plus-size (Black) women's ability to live a dignified life is in jeopardy. This is because no one can live a dignified life if they experience chronic stress, "digestive upset, headaches, sleeplessness, irritability, sadness [...] heart disease, high blood pressure, diabetes,

depression, and anxiety" due to a mental illness reinforced by fatphobia, misogyny, and racism. HAES foreshadows the major impacts it would have on the human dignity of plus-size Black women seeking medical assistance (Falk 2021; Kadivar, Mardani-Hamooleh, and Kouhnavard 2018), given that HAES assists in creating a medical environment that would validate fat Black women's medical concerns. Subsequently, larger Black women's feelings of anxiety and shame when visiting doctors will decrease, while their chances of improving their physical health will increase. HAES' ability to decrease (medical) stress is especially prevalent for eating disorder sufferers attempting to overcome the illness. This is due to HAES and the Body Neutrality Movement deprioritizing calories, acknowledging that one does not have to constantly adore the way they look, and prioritizing how one can appreciate themselves beyond their appearance (Fuller 2021; Kessel 2018; ASDAH 2022b; Falk 2021). Maintaining good physical and mental health is essential for living one's life with dignity since good physical and mental health implies that a person is living adequately (United Nations 2020; Kadivar, Mardani-Hamooleh, and Kouhnavard 2018).

HAES principles advertise social mobilizations that utilize social media platforms like Instagram. The practice believes that raising awareness about body neutrality, and supporting body neutrality advocates, will help strengthen the Body Neutrality Movement's message (Falk 2021). Body neutrality campaigners on social media use their platform to raise awareness of how fatphobia, especially when exhibited by diet culture, can have dire consequences. For example, Latoya Snell, a plus-size Black supporter of HAES, used her online presence (especially on Instagram) to share her experiences with diet culture. She claimed that following a lifestyle consisting of a severe calorie-deficit diet, 12-hour workdays, and four hours of sleep led to her hospitalization. After her hospitalization, Snell decided to become body neutral. Snell made the active decision to stop chasing the thin ideal because she wanted to ameliorate her relationship with food, ignore body shamers, strengthen her stamina, and not have her weight dictate how dignified her life was. She accomplished this by creating a blog called "Running Fat Chef" where

she shares her journey with HAES. She also publishes articles for various online publications and speaks to other media outlets about her experiences with fatphobia and racism. Snell also takes socio-political initiatives, such as "speak[ing] to small and large groups about body politics, self-love, fitness at all sizes, inclusion, and diversity in the fitness, food, and wellness space" (Snell 2020).

Snell exemplifies how the Body Neutrality Movement removes the socio-racial connotations affiliated with your body to ensure that your health and mental well-being are prioritized so that plus-size Black women can live dignified lives. In the medical context, human dignity towards yourself includes prioritizing your (mental) health (Jones 2015). Snell's actions indicate the presence of the social movement theory's third aspect. The HAES principles enabled Latoya Snell to focus on her personal experiences with fatphobia, racism, and fitness, which led her to personally connect with body neutral concepts and movements (Ballard, Habib, Valodia, and Zuern 2005). Snell's advocacy also showcases hope for plus-size Black women, including those with eating disorders, to preserve their human dignity towards themselves. Snell and HAES exemplify hope by proving that it is possible to make a full physical recovery from food-related health concerns by removing the stigmatizations correlated to a plus-size, Black, and femme-presenting body. Furthermore, HAES and Snell give hope that one can (re)connect with their body and (re)prioritize their body's physical and psychological needs. Meanwhile, HAES demonstrates how the individual approach toward human dignity can be realistically practiced, by prioritizing a patient's need for gracious medical attention rather than dismissing a patient's medical concerns due to their size, race, and gender (Kadivar, Mardani-Hamooleh, and Kouhnavard 2018, p.5).

To summarize, the social mobilizations of the Body Neutrality Movement can ameliorate the dignity of fat African American women utilizing healthcare facilities by making socio-institutional paradigm shifts in the way health is understood. The best representation of this paradigm shift is the HAES principles, which emphasize the equal treatment of patients and weight neutrality.

Furthermore, representatives of the movement, such as Latoya Snell, give hope for fat Black women with eating disorders to decentralize weight loss and apply this decentralization in all aspects of their lives, including expressing their medical concerns to healthcare professionals. On the other hand, the Fatosphere showcased that it can help fat people be heard in medical spaces. However, the online forum's implicit pursuit of thinness, combined with the lack of African American voices, demonstrates that the social mobilizations of the Fat Acceptance Movement may not be enough to help women who are both fat and Black.

To conclude Chapter 5, this chapter reviews the emergence of the Fat Acceptance Movement, the Body Positivity Movement, and the Body Neutrality Movement. Chapter 5.1 argues that the Fat Acceptance Movement and the Body Neutrality Movement trump the Body Positivity Movement due to their stronger political, legal, and medical stances. Moreover, the Body Positivity Movement is less inclusive. Chapters 5.2 and 5.3 conclude that; although both the Fat Acceptance Movement and the Body Neutrality Movement have taken socio-legal initiatives, the Fat Acceptance Movement has more substantial legal mobilizations while the Body Neutrality Movement has more substantial social mobilizations. Both mobilizations have displayed that they can improve the integrity of fat Black women treating their health issues in the U.S medical sphere. Given the findings provided in Chapter 5, alongside the information and analyses presented in the previous chapters, this MA dissertation may conclude itself.

Chapter 6: Conclusions

In conclusion, human dignity as a human rights and medical concept is generally understood as the right to exercise your human rights (especially the rights declared in the UDHR) while also showing respect to yourself and others (in medical spaces). However, human dignity in the medical and human rights contexts is not universally practiced in the United States due to the country's history of sexism, sizeism, and racism. Contemporary research studies, alongside American medical history, indicate that the U.S medical sector specifically uses anti-fat and anti-Black approaches towards plus-size feminized Black bodies with health disparities, including those with eating disorders. In fact, the U.S medical sector mistreats and belittles fat Black women due to not meeting Eurocentric interpretations of health and beauty. Subsequently, fat Black women experience more difficulty with having their human dignity respected and maintained when requesting medical help.

Intersectionality as a theoretical framework explained how oppressive socio-institutional and medical structures violated large African American women's capability to practice their human rights. This is due to these oppressive structures preventing plus-size Black women from protecting their right to health, their right to life, their right to equal treatment, and their right to a high quality of living. This was best reflected by the 2015 case of Barbara Dawson, as well as the intersectional interpretation of fat women's experiences with eating disorder treatment. The utilization of case studies as the RP's methodology helped emphasize the importance of redefining human dignity in a way that would condemn anti-fat and anti-Black medical practices. Furthermore, the case studies highlighted that plus-size Black women with health problems need to receive the respect they intrinsically deserve. Real-life examples from the Body Neutrality Movement and the Fat Acceptance Movement were also analyzed to evaluate their abilities to enact socio-legal changes favoring the dignity of large African American women. The Fat

Acceptance Movement is defined as a social justice movement aimed at counteracting the injustices fat people face and improving fat people's quality of life. Meanwhile, the Body Neutrality Movement is defined as an intersectional social justice movement that encourages the practice of body neutrality in social, political, medical, and personal spaces.

The Body Neutrality Movement and the Fat Acceptance Movement have the potential to mobilize the human dignity of plus-size Black women seeking medical assistance in the United States when their social and legal mobilization efforts are combined to protect fat Black women's integrity. The Fat Acceptance Movement's potential is most prevalent through the foundational legal structures established by the National Association to Advance Fat Acceptance (NAAFA). NAAFA has established working relations with American senators who prioritize combatting fatphobia in healthcare and in other social arenas; created accessible online resources, such as #EqualityAtEverySize, that enable Americans to initiate legal changes for fat (Black) women; and has a rich history of successful protests stemming from the 1960s, such as the fat-ins. The potential of the Fat Acceptance Movement was accentuated by its parallels with social movement theory and "new" social movements, two of the three theoretical frameworks applied onto this MA thesis.

The Body Neutrality Movement's potential to enhance the human dignity of fat African American women requesting health services is best displayed through the movement's social mobilizations. The Association for Size Diversity and Health (ASDAH) has demonstrated their potential to improve the human dignity of plus-size Americans through the organization's resemblance to the characteristics of social movement theory and "new" social movements. This is reflected through ASDAH's coalitions, conferences, and fundraisers. Additionally, Latoya Snell's dedication to the Health at Every Size (HAES) principle also reflects the Body Neutrality Movement's competence to be a legitimate social movement that can benefit fat Black women. ASDAH and the Body Neutrality Movement have showcased their capability to help destigmatize fat Black women's bodies in medical spaces through prioritizing intuitive living (including intuitive

eating) and weight neutrality. Intuitive living reinforces the importance of inner peace, which is an essential component of human dignity in the medical context.

The socio-legal mobilizations of both movements can be beneficial for plus-size Black women's human dignity in American medical spaces since both movements remind the U.S healthcare sector to not make presumptions about a fat Black woman's health based on her physique, showing her respect regardless of her intersectional positionality, and providing her with the medical services she needs to improve her health. Furthermore, the Fat Acceptance Movement and the Body Neutrality Movement have the means to establish socio-legal reforms in favor of plus-size Black women's lives and fight for the human rights of fat (Black) people when the medical sector infringes on their rights.

The arguments, examples, and analyses presented throughout this RP demonstrate the urgency to improve the human dignity of fat African American women navigating American medical spaces. A recommendation to ameliorate fat Black women's human dignity is for American medical spaces to incorporate HAES principles into medical school curriculums, especially medical programs that specialize in eating disorder recoveries. Furthermore, more African American and/or plus-size medical professionals should be involved in eating disorder treatment plans for Black and/or plus-size patients, along with being writing contributors to insurance policies. Fat and/or Black women doctors could help empathize with patients' experiencing misogynoir and fatphobia, especially within the American context. Moreover, fat and/or Black women doctors could also help tackle these injustices from within the U.S healthcare sector. Another suggestion is for medical practitioners to attend diversity and inclusion workshops that would help combat any weight, gender, or racial biases medical practitioners may have toward their patients. These workshops should also raise awareness about the importance of human dignity in both the human rights and medical contexts. Regarding the social movements mentioned throughout the dissertation, I suggest that ASDAH and NAAFA provide more transparency about their Abolish

BMI coalition, as well as start more intersectional socio-legal collaborations to ensure the protection of plus-size Black women demanding medical attention.

There are various ways in which this academic paper can be further expanded and explored. For instance, one can discuss how fatphobia and racism affect African American men or non-binary African Americans who are seeking medical care. This dissertation can also be further specified, such as focusing on how a certain state or American city approaches the human dignity of their ill plus-size African American patients. Furthermore, investigations on how different communities of color in the U.S (e.g Native Americans, Asian Americans, Arab Americans, Latin Americans, etc.) are affected by racist, sexist, and sizeist practices in American healthcare can be conducted. The intersections between fatphobia, racism, and sexism are not exclusive to the American healthcare system. Academic research focusing on these multi-faceted discriminations in different societal spaces – such as in the media, the judicial system, or in the workforce– can take place to better understand human dignity in the human rights context, and how to preserve it. Lastly, other compelling theoretical frameworks could be implemented into the topic of intersectional discrimination, such as Critical Race Theory.

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