Fat – Therefore, Unhealthy? Oppressing Fat People in the Name of Health

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Abstract

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This dissertation is primarily a response to the concern for health objection that is frequently used in an attempt to discredit the fat acceptance movement. I offer a critical understanding of "health" in relation to fatness and argue that dominant understandings of the relationship between health and fat have perpetuated the oppression of people in larger bodies. Fat oppression has taken different forms over time and is currently disguised as a concern for health and well-being. However, this seemingly legitimate reason for demonizing fatness is also what makes this kind of oppression more insidious.

The dissertation is organized as follows. Chapter one advances an understanding of fat oppression as a kind of cultural imperialism perpetuated in today's society through an overly pathologized narrative of fatness as being antithetical to health. In chapter two, I argue that the dominant and overly medicalized perspective of fatness is communicated to society via a

medical model of fatness and that obesity researchers have relied on medical model assumptions in ways that impede both our epistemic aim of generating accurate knowledge about the body and the social aim of improving health. Chapter three provides more motivation for my argument that the medical mode is the primary underlying problem perpetuating fat oppression today by explaining how it plays a central role in the epistemic injustice that people in larger bodies experience. I argue that the medical model should be understood as a deeply entrenched ideology that has unknowingly shaped our social practices in a way that is unjust and yet appears justified. For this reason, simply critiquing agents for not cultivating epistemic virtues or critiquing the ideology itself will not help us achieve justice – this will require that we change the social meanings that inform our actions. Chapter four offers an alternative view of fatness to replace the medical model – the value-neutral model of fatness – which interprets fatness as something that is neutral with respect to well-being. The concluding chapter demonstrates how this alternative view of fatness – as well as things like epistemic friction, participatory research, and education in critical weight studies – can support fat activists' efforts toward achieving fat liberation.

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Chapter 1: Reconceptualizing Fat Oppression as a Form of Cultural Imperialism

1. Introduction

Widespread reports in the media depict that our contemporary society is struggling with an "obesity epidemic" (Lee 2019; Galvin 2020; Dietz 2019; Newman 2019). The increase in the number of people with body types that are commonly described as fat is often used to invoke a sense of moral urgency. Yet describing the rising numbers as an epidemic, which assumes the prevailing understanding of fatness as a detriment to health, is morally disconcerting. In the past few years, fat activists have strongly pushed back on these pathologized notions of fatness. They have shared their own lived experiences and research to show that fatness itself does not necessarily lead to a decrease in well-being. For instance, Nomy Lamm, a gay, fat, and disabled activist writes:

> I can honestly say that I love my body and am happy with being fat. But occasionally, when I look in the mirror and I see this body that is so different from my friends', so different from what I'm told it *should be*, I just want to hide away and not deal with it anymore. At those times it doesn't seem fair to me that I have to always be fighting to be happy . . . But I know that the unhappiness [is] *not a result of my fat. It's a result of a society that tells me I'm bad.* (Lamm 1995, emphasis added)

Fat activists are speaking up about their relationships with their bodies. Despite being generally happy with her own body and its capabilities, Lamm claims that it is living in a society that tells her that her body is wrong or bad that causes her suffering – it is not her body. Our overly medicalized perspective on fatness does not accurately represent the relationship between fat, health, and well-being.

As a society, we assume many things about people in larger bodies[1] solely because of their body size. For example, implicit bias research shows that our judgments about fat bodies do not merely stem from *a concern for health*, but also from a belief that people in larger bodies embody certain character flaws – e.g., they are assumed to be lazy, untrustworthy, incompetent (Eaton 2016). This concern for the health of people in larger bodies is also used to delegitimize fat activism. However, given the abundance of research showing the drastic negative effects that

[1] Though the terms "overweight" and "obese," are often used to describe people in larger bodies, fat activists consider it a slur (Chastain 2020). For that reason, I will often use the phrase "people in larger bodies" to describe those whose bodies are being described in this medicalized way. Fat activists are reclaiming the word *fat*, which is taken to be a political identity, to contest shame, express power, and expose the limitations of the medicalized language (Cooper 2016).

weight stigma and other social determinants[2] have on health, the association between ill health and fatness is far more complex than most people realize. Stereotypes related to purported character flaws negatively affect the education, career opportunities, economic status, medical care, and general well-being of people in larger bodies because society uses "weight as a proxy for humanity and morality" (Tovar 2018). This sentiment has been echoed by other fat activists:

> I am five-feet four-inches tall, and I weigh 270 pounds. My blood pressure, cholesterol, and blood sugars—the three best health indicators—are all normal. I have no history of serious illness. I don't smoke. I exercise and eat my vegetables. I brush my teeth and pay my taxes and wear a seat belt, yet from my most personal moments…to my official business... I was shut out because of a number on a scale. (Wann 1998, 10)

Many people assume people in larger bodies do not take care of themselves and that they are failing in their personal (and moral) duties to themselves and others – that is, assumptions are made about the kind of people they are merely because of the presumption that they are choosing to have body types that are intrinsically unhealthy and welfare diminishing.

The burgeoning fat acceptance movement aims at fostering a more positive and inclusive attitude towards fatness as a morally unobjectionable form of embodiment, but this movement faces significant resistance. For example, in response to the fat-positive comments pertaining to American singer-songwriter Lizzo,[3] celebrity trainer Jillian Michaels said: "Why are we celebrating her body? Why does it matter? Why aren't we celebrating her music? 'Cause it isn't going to be awesome if she gets diabetes" (Chiu 2020). Michaels is clearly concerned about the health issues commonly associated with being fat and uses this to justify her disapproval of the fat acceptance movement. Similarly, conservative commentator Candace Owens described the

[2] The World Health Organization (WHO) defines the social determinants of health (SDOH) as "the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems" (https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1). Definitions of SDOH vary in that some, like the WHO, explicitly leave out medical factors while others include them because medical factors affect and are affected by other social factors (e.g., poverty, race, sexuality, gender). I understand SDOH as including medical factors because in the context of fatness, medical factors (e.g., body mass index [BMI] classification) clearly influence other non-medical factors (e.g., insurance coverage and job stability) and non-medical factors (e.g., weight bias and stigma) affect medical factors (e.g., increased risk of hypertension).

[3] Lizzo is known not only as being an award-winning singer-songwriter, rapper, and musician, she is also known for being an activist for body positivity and Black women. Her activism is expressed through the music she writes, the way she carries herself on stage, and through her social media accounts (e.g., Instagram: @lizzobeeating). As an article in *Rolling Stone* put it: "[Lizzo] has become, at 31, a new kind of superstar: a plus-size black singer and rapper dominating the largely white and skinny pop space, all while being relentlessly uplifting and openly sexual on her own terms" (Spanos 2020).

movement on Twitter as "fashionable stupidity [that] needs to stop" (Owens 2020). In a response to a comment, she further explained how this movement should be "shamed" because "it's unhealthy and wrong" (Ibid.). Not all reactions to the fat acceptance movement are quite this extreme in terms of explicit disdain, but the general sentiment is widely shared.

The pushback also comes from across the political spectrum. Former first lady Michelle Obama, for instance, is known for her role in combating childhood obesity with her public health campaign called "Let's Move!" This health initiative calls for changes such as improving the quality of food served in schools, which includes increasing the servings of fruits, vegetables, and whole grains, and decreasing the amount of added salt and sugar in school meals (Let's Move!, n.d.). While fat activists have not flagged these kinds of changes as worrisome, the messages that these reforms will make kids *thinner* is problematic. Focusing on what children look like rather than their actual health is troubling.[4] Even Daniel Callahan, a pioneer of biomedical ethics, argued in favor of a position that amounts to fat shaming, noting that a serious intervention is necessary – one that consists of "social pressure combined with vigorous government action" (Callahan 2013, 39). Even if these recommendations come from people who are genuinely concerned about the health and well-being of fat people, they nonetheless reinforce an ideology of fatness, which conceptualizes fatness as a pathology and thus, a type of embodiment that is inherently bad.

In this chapter I work toward developing a comprehensive understanding of fat oppression through the lens of cultural imperialism and by relying heavily on interdisciplinary research and the testimonies and scholarship of fat activists. My view builds upon the work of other philosophers who have attempted to make sense of weight stigma in relation to aesthetics, gender, disability, and politics. Earlier feminist philosophers (e.g., Sandra Bartky [1990] and Susan Bordo [2003]) have considered ways in which gendered cultural norms enforce an unfair constraint on women's bodies in particular. Since the publication of these earlier feminist texts,

[4] For example, it is said that what inspired Michelle Obama to launch a campaign fighting childhood obesity was her own experience with her children. The former first lady has openly discussed how during a regular check-up, the pediatrician warned her that her daughters had gained a little too much weight since the last check-up (i.e., according to their BMI). This "problem" was addressed immediately – the family made changes to their diet and lifestyle in response to this new information – although from the research I have done, nothing was said about the daughters' other health markers, e.g., heart rate, blood pressures, cardiovascular fitness (Susan Hayes, "Mom on the Move: A surprising conversation with Michelle Obama's daughters' pediatrician inspired the first lady to launch her Let's Move campaign for healthy children," in *Scholastic*, accessed March 2, 2020, http://www.scholastic.com/browse/article.jsp?id=3753960).

other philosophers have also contributed to the philosophical literature, such as G.M. Eller [pseudonym for Madeline Ward] (2014), Reiheld (2015, 2020), Eaton (2016), Nath (2019, forthcoming), and Manne (2022, forthcoming).

Philosophers of disability, for instance Elizabeth Barnes (2015), have discussed other commonly negatively viewed bodies, like disabled bodies, and have argued that such bodies are not inherently negative. Rekah Nath (2019) has evaluated the most plausible arguments for justifying fat stigma and ultimately argues that these arguments fail.[5] Alison Reiheld (2020) has articulated some of the epistemic injustices related to fatness, and she has also argued that the way public health efforts individualize responsibility to combat "obesity" is deeply problematic (2015). A.W. Eaton (2016) has argued that society has an aesthetic distaste for fat bodies and that this distaste for fat bodies is what makes it difficult for our society to overcome fat phobia. Kate Manne (2022) has more recently taken an interest in exploring the immorality of diet culture. And Madeline Ward (G.M. Eller 2014) has argued, as I will do in this chapter, that the suffering that people in larger bodies experience is a result of fat oppression. While these discussions about weight-based stigma and oppression offer important insights, to date, there hasn't been a more comprehensive philosophical analysis of the multi-faceted, structural, and pervasive injustices that collects these oppressive norms and practices together. While others (like Nath, Reiheld, and Ward/Eller) have understood fatness as a site of injustice, what sets my view apart is in the way that I frame fat oppression as a kind of cultural imperialism (Young 1990) perpetuated today via a dominant narrative about fatness as antagonistic to health. This framework for understanding fat oppression improves upon this literature by articulating how multiple different but entangled dimensions of cultural norms entrench anti-fat practices, and also because it relies on and can account for the rich contributions from other disciplines.

Not to discredit the work that has been done in philosophy and disability studies, but the most comprehensive literature on fat oppression has mostly come from scholars in other disciplines – e.g., sociology (Strings 2019a, 2019b; Saguy 2013), women and gender studies (Cooper 2016; Farrell 2011; Herndon 2002; Mollow 2015), communications (Lebesco 2001, 2004), education (Gard and Wright 2005), political science (Oliver 2006), history (Gilman 2004), and law (Campos 2005; Solovay 2000) – and some of the most enlightening information has come from the testimonies of fat activists – e.g., Charlotte Cooper, Aubrey Gordon, Tressie

[5] See also Nath (forthcoming) for a thorough explanation of "why it's OK to be fat."

McMillan Cottom, Roxanne Gay, Kiese Laymon, Virgie Tovar, Sonya Renee Taylor, Lindy West, Esther Rothblum, Sondra Solovay, Cat Pausé, and Nomy Lamm. It is from these sources that I draw much of my information in developing an account of fat oppression as a form of cultural imperialism.

In particular, I argue that society's seemingly legitimate pursuit of the cultural value of health has served as a cover for fat oppression. The dominant narrative about fatness preserves the common anti-fat biases and stereotypes about people in larger bodies (e.g., that they are lazy, unreliable, incompetent, etc.), and the narrative is believed to be justified because it is grounded in concern for people's health. To make this argument, I will employ Iris Marion Young's conceptions of "oppression" and "cultural imperialism" to explain why we should understand the experiences of people in larger bodies as oppressive and as a result of cultural imperialism. The personal testimonies of people in larger bodies, alongside empirical data from critical fat studies, will lend support for my argument that this social group is oppressed, and the history of weight stigma and its racist and sexist origins will lend support for my argument that where blackness (which was equated with fatness) was once used to justify weight stigma (Strings 2019a; Strings 2019b), a biased conception of health has taken its place.

2. Why Oppression?

Oppression is a condition of injustice that constrains a person's capacity for self-development, which is influenced not only at the levels of institutional organization and public action, but also at the levels of social practices, habits, and cultural meanings. Oppression is also something that happens to social groups by other social groups. Oppression affects a person's ability to: (1) express thoughts, feelings, and experiences, (2) receive a fair distribution of wealth, income, and other resources, (3) gain power, autonomy, authority, status, or respect, and (4) be free of harassment, intimidation, or ridicule (Young 1990). The multifaceted ways in which oppression systematically constrains the possibilities and choices of subjugated social groups illustrate the structural nature of oppression (Frye 1983). As Young explains it, oppression today often occurs "as a consequence of often unconscious assumptions and reactions of well-meaning people in ordinary interactions, media and cultural stereotypes, and structural features of bureaucratic hierarchies and market mechanisms—in short, the normal processes of

everyday life" (Ibid., 41). Oppression may refer to various kinds of injustices including powerlessness, marginalization, exploitation, violence, and cultural imperialism (Young 1990).

Young does not apply her framework of oppression to the experiences of people in larger bodies – indeed many theorists who explore intersecting oppressions nonetheless fail to recognize fat oppression as oppression – but I aim to show how it is appropriate in this context. People in larger bodies constitute an oppressed social group – like women, people of color, and disabled people – because they too are assigned a lower social status and deprived of access to some social goods, both as a result of some property they possess. People in larger bodies are very frequently (whether implicitly or explicitly) stereotyped and marked out as Other, and often have difficulty finding appropriately sized chairs, desks, and seats (e.g., in planes, theaters, restaurants, classrooms, and other public spaces) and clothing that fits appropriately. They also experience workplace discrimination (e.g., in regard to hiring, wage, and promotion and termination), get teased and bullied (particularly as children and adolescents), are excluded from social standards of beauty and desirability, and often do not receive proper medical treatment (Eaton 2016, Tirosh 2012, Cooper 1997). In a society that positively values a slender body and the underlying virtues that are associated with it (e.g., self-restraint, moderation, beauty, innocence, righteousness), the fat body is marked out as different and deviant, and the fat person is attributed with characteristics that justify their differential treatment (e.g., delinquent, ugly, lazy, sinful, gluttonous). This process of creating a group that is marginalized and subject to discrimination, exclusion, etc. is key to Young's understanding of oppression (Young 1990). In Young's framework, the existence of a social group depends on its relation to other groups. In other words, social groups form when a group of people share a special affinity with one another due to sharing similar cultures, practices, experiences, or ways of life and are differentiated from at least one other group of people in at least one of these ways. People in larger bodies have formed a social group as a result of being on the receiving end of anti-fat bias and discrimination, and having discernable experiences from non-fat people who experience some degree of thin privilege.

Most people use the terms "overweight" or "obese" to describe people in larger bodies and they do so with the underlying belief that they have a particular health condition, because "obesity" is now considered a disease (Pollack 2013). However, the term "fat" describes a bodily attribute that is shared among people in larger bodies, and many fat activists positively identify

themselves in this way. While people in larger bodies have been placed in a stigmatized social group that was and still is "forced upon them," many fat activists are making efforts to reclaim this identity and to forge a new social status. Instead of having "fat" mean something derogatory, fat activists want it to be used just like any other word that describes bodies in a neutral way (e.g., tall).

So how do *I* understand fat? Who am I referring to when I mention "people in larger bodies"? I believe there is a spectrum of fat and all "people in larger bodies" fall somewhere on this spectrum. People have various amounts of adipose tissue on their bodies, and the amount of adipose tissue people have on their bodies affects how they are treated. The greater the percentage of your body that is made up of adipose tissue, the more barriers you will face. The smaller the percentage, the more privilege (i.e., "thin privilege") you have. For example, Roxanne Gay says, there's "Lane Bryant Fat" to refer to fat people who can still shop plus sizes, and these individuals have some degree of privilege when compared to other people on the spectrum who have to buy clothes online or buy custom made clothing (Gay 2017). Other fat activists have also described there being categories such as "Small Fat", "Medium Fat", "Superfat", and "Infinifat" (Ash 2016). Another fat activist and fat justice scholar, Charlotte Cooper, says, "There is no universal measure or mark that constitutes what is and what is not fat; fat exists in context and experience; fat people know who they are and are known as fat by others" (fn 1, 1). There is no objective way to determine who is fat and who is not – it is informed by societal norms and values surrounding body size and one's lived experiences living in that society. "Fat" is a social construct.

3. Problems with Previous Conceptions of Fat Oppression

A comprehensive account of fat oppression should attend to the historical development of weight stigma and how it has influenced today's "obesity epidemic" framework. Formulating a theory of fat oppression abstractly, outside of its historical and social context, will be unhelpful in developing appropriate solutions to the problem. Scholarly work on fat that addresses only gender, or race, or disability may fail to appreciate the common thread that strings these features of fat oppression together. Previous philosophical discussions of fat injustice or weight stigma have either: (1) provided an incomplete historical analysis thereby underemphasizing the significance of race, (2) downplayed the ways it affects men and trans and queer folks, and/or (3) downplayed the connections it has to the "obesity epidemic" and "obesity research" by

ineffectively explaining the role *health* has played in perpetuating the injustice, and (4) have had little to no engagement with the testimonies of fat activists. What I aim to offer is a broader and more comprehensive understanding of fat oppression that accounts for its racist and sexist history and how it affects various social groups, explains how this form of oppression preserves itself by adapting to fit evolving societal values, and helps to identify solutions required to achieve fat liberation.

3.1. Narrow Feminist Conceptions of Fat Oppression

The attention that previous philosophical work on the topic of fat oppression has given to the experiences of women is not surprising, especially given the role that religion has played in the development of weight stigma and the history of the fat acceptance movement. Professor of Religion Michelle Mary Lelwica explains how even as far back as ancient history, "the immorality of eating was gendered" (2017, 106). From the fourth and fifth centuries through the Middle Ages, restraint in eating and fasting were thought to exemplify moral superiority. Fasting, in women especially, was praised because it was thought to make them less lustful and more desirable in the eyes of God. Though health had nothing to do with these early beliefs about the value of the slender body, a slender body was nevertheless thought to represent virtuousness, discipline, and beauty (Lelwica 2017).

The origins of the fat acceptance movement are also intertwined with the experiences of women and feminism. The fat acceptance movement is often said to have started with the creation of the National Association to Aid Fat Americans (today known as the National Association to Advance Fat Acceptance, or NAAFA) in 1969, though there are some earlier documented examples of fat activism (see Cooper 2016). NAAFA got started when two husbands, Llewellyn Louderback and William Fabrey came together to fight against the discrimination that their wives were experiencing. Despite the respectable motivation behind starting NAAFA, the women in the organization experienced marginalization, sexual harassment, tokenism, and were actively prevented from accessing organizational power (Ibid.). The political rift between fat feminists and conservative members, in addition to problems of sexism and homophobia, is what prompted the feminists to leave NAAFA and start a new organization called The Fat Underground in the early 1970s. Members of The Fat Underground went on to use "feminism as a theoretical basis for their activism" (Ibid., 120). In other words, fat oppression even among fat activists at the time was very much understood through a feminist

lens – it was understood as a component of patriarchy (Cooper 2016; see also Lepoff et al. 1983).[6]

Building on these second wave feminist ideas, philosophers who have written on body politics and anti-fatness have acknowledged in varying degrees the ways in which other social identities – e.g., race and class – influence cultural interpretations and expectations of women's bodies. However, they nevertheless focus mostly on experiences that are clearly not representative of all women. For example, in her book *Unbearable Weight*, Susan Bordo focuses much of her analysis on the gendered dimensions of food and body norms. To demonstrate how "even in our disorders we follow the gender rules," Bordo (2003, 129) writes:

> More often than not…women are not even permitted, even in private, indulgences so extravagant in scope as the full satisfaction of their hungers. Most commonly, women are used to advertise, not ice cream and potato chips…but individually wrapped pieces of tiny, bite-sized candies… the message to women is explicit: 'Indulge a little.' (And only out of sight; even these minuscule bon bons are eaten privately, in isolation, behind closed doors).

The (white) gender binary of disciplinary practices is also illustrated in the book *Femininity and Domination*, when Sandra Bartky says "it is women themselves who practice this discipline on and against their own bodies….The woman who checks her make-up half a dozen times a day to see if her foundation has caked or her mascara run… or who, feeling fat, monitors everything she eats, has become… self-committed to relentless self-surveillance. This self-surveillance is a form of obedience to patriarchy" (1990, 80). Other (non-philosopher) feminist scholars, such as Orbach (1978), Wolf (1990), and Chernin (1983), have echoed similar concerns about the role of patriarchy in policing women's bodies.

In response to the lacuna in the literature about the role of race and class in the development of the thin ideal and anti-fatness, sociologist Sabrina Strings, among others, sheds light on how "fear of the black body was integral to the creation of the slender aesthetic among fashionable white Americans" (2019b, 212). Strings claims that the thin ideal and condemnation of fatness initially took root in the U.S. owing to Protestant moralism and race science. Both Protestant moralism surrounding food and bodies and race science made way for linking fatness to blackness and thinness to whiteness. The image of the "fat black woman" was created amidst

[6] However, The Fat Underground's analysis of fat oppression didn't stop there. They understood fat liberation as working in alliance with the struggles of other social groups, including racism, capitalism, and imperialism (Cooper 2016).

the growth and reform of Protestantism in the late 1800s to degrade black women and to discipline white women (Strings 2019a, 2019b). The protestant middle-class transformed bodily ideals: the ideal of fatness, which at one point was connected with wealth and status, slowly became surpassed by the ideal of thinness in the industrial age during which things such as "rationality, efficiency, and self-discipline" were admired (Oliver 2006, 68). The restraint of bodily desire was not only seen as a means to wealth and status, but it also made one virtuous (Oliver 2006). It wasn't until after slenderness was being increasingly promoted in the media for white Anglo-Saxon protestant women at the beginning of the 20th century that the medical establishment began making excess fat a public health concern (Strings 2019a, 2019b). The work of Strings, in combination with a number of other scholars, has made the point that anti-fatness, which has been intimately connected with the historical development of whiteness in the United States (Farrell 2011; Strings 2019a, 2019b; Harrison 2021), has been used as a way to mask overt racism in the name of "health" (Oliver 2006; Saguy 2013; Herdon 2014; Stoll 2019; Boero 2009)

The lingering effects of racism are still present in fat oppression and are often not accounted for in feminist accounts of anti-fatness. One way in which Black women are harmed by fat oppression is in the way their bodies are interpreted in the context of eating disorders. For example, despite the general belief that Black women do not often develop eating disorders, the rates of binge eating disorder (BED) are "disturbingly high among Black women, who report being more functionally impaired, have more severe associated mental health consequences, and demonstrate lower levels of help-seeking behavior than white women" (Parker et al. 2013, 345). Previous white feminist accounts also do not explain how sodas, which are often blamed for contributing to the "obesity epidemic" and are sometimes *taxed* to reduce consumption, are a must-need *staple* in low-income homes because they are shelf stable, cheaper than juice, a crowd pleaser, and free of mold, fungicides, and lead (Kendall 2020). They also fail to mention the immense pressure and blame placed on Black mothers who were viewed as "ground zero" of the "obesity epidemic" due to their perceived noncompliance in breastfeeding (Nash 2021). White feminist accounts of anti-fatness also tend to obscure the important way in which Western narratives of beauty – which are deeply rooted in colonialism and capitalism in addition to patriarchy – have been used as a colonial tool that "keeps Indigenous women from reconnecting with more traditional, holistic, and community-based ways of expressing beauty" (Blackmoon 2020, 214).

The experiences of men and trans and queer folks also often get overlooked in white feminist accounts of anti-fatness. For example, they fail to mention the history of the body in the world of sports and pressures to achieve one's goals influenced men to go on very dangerous crash diets because "fat people don't make good athletes" (Gilman 2004, 194).[7] They ignore how Black boys and men develop eating disorders in response to the trauma they experience in a racist society – to regain some sense of control and to try to forget (Laymon 2018). Nor do they consider how:

> [F]atphobia functions as a weapon of antiblack violence: by deflecting attention from the injuries that the state imposes on black people's bodies (whether through poisoned water or police violence), antifat discourse shifts the focus to the alleged bad dietary choices of African Americans, discursively rendering them unvictimizable. (Mollow 2017)

Additionally, these white feminist frameworks often ignore the fact that trans and nonbinary people are more likely than cisgender people to develop eating disorders as a result of experiencing not just body dissatisfaction but also gender dysphoria (Harrop et al. 2023).[8] The multifarious harms that result from fat oppression are extensive and insidious and deserve close attention and interrogation.

3.2. The Role of "Health" in Fat Oppression

Another way in which many previous philosophical frameworks of fat oppression are inadequate is in their failure to recognize or explain how the injustice is being perpetuated in health care policies, medical recommendations, and obesity research. The role *health* plays in fat oppression goes hand in hand with its racist and sexist origins. As Strings (2019, 164) puts it,

> For although doctors since the time of George Cheyne [in the seventeenth and early eighteenth centuries] had been telling corpulent people to lose weight for God, and race scientists [in the late eighteenth and early nineteenth centuries] had been urging elite white Americans [and particularly white women] to stay slim for country [exceptionalism], *medical science would in the twentieth century step in to tell Americans to get trim for health reasons*. (emphasis added)

[7] Gilman (2004) gives an example of Babe Ruth who out of fear that his weight gain was affecting his game, went on a dangerous crash diet to lose weight and lost 21 pounds in twenty days. His drastic weight loss attempts "may well have played a role" in his collapse (Ibid., 198).

[8] Gender dysphoria is the extreme physical and emotional discomfort caused by perceiving one's body as incongruent with one's gender

What remains consistent in the evolving reasons for denigrating fatness is that societal values are being determined by the oppressors (i.e., wealthy white men), and at the turn of the twentieth century, the "normalizing gaze of science" was able to endow these values with objective truth (Young 1990, 128). This relationship between racism and the value of health is echoed by other scholars. For example, anthropologist April Herndon says, "many of the same attitudes and actions toward women of color and/or poor women that would be called *discriminatory* in another situation can be couched as *justified* – or even helpful – when read through the lens of fatness because such claims are supposedly about *health*" (Herndon 2014, 45, emphasis added; see also Oliver 2006; Saguy 2013). Amy Farrell also argues that "fat denigration is intricately related to gender as well as … the historical development of whiteness" and recognizes "the interplay between earlier ideas of fat denigration and the contemporary manifestations of fat stigma…that *couched fat denigration simply as concern over people's health*" (2011, 4-5, emphasis added). What makes fat oppression particularly insidious is that the denigration of fatness has been "naturalized" and viewed as a truth about the nature of the human body (Young 2011).

Early fat activism was also interested in critiquing the medicalization of fatness and the medical exploitation of fat bodies. Activists who spearheaded the movement – e.g., Judy Freespirit and Sara Aldebaran – criticized other analyses of fatness that "fail[ed] to connect fat oppression to wider social structures… ally it with other liberation movements… [or] provide an account of it within medicalisation or moral discourse" (Cooper 2016, 122-123). Fat activists recognized early on that obesity research and the medical recommendations and policies that stem from it are intricately interwoven into fat oppression and thus, need to be challenged. Building on these activists' views, I argue that a critique of the medicalization and depoliticization of fat embodiments – which occurs when people raise concerns about health – is needed (Ibid., 117). My approach to conceptualizing fat oppression applies the rich information provided by interdisciplinary scholars to a philosophical framework of oppression that specifically views the injustice as a result of cultural imperialism.

The fundamental problem with fat oppression is not only the stigma that is attached to the fat body but rather, the moralization of health. In today's society, stigma is attached to the fat body because health is understood as the antithesis of fatness, and the fat body is believed to be effectuated by unhealthy choices and lifestyles. Even if we were to remove the stigma associated

with fat bodies, however, we may still "reinforce the moral imperative to engage in healthy lifestyles" (Saguy and Riley 2005, 896). The morality attributed to healthy lifestyles like eating a balanced diet and exercising regularly would still be a problem when we consider, for example, who has the time, access, and resources to do these things. We would still view these people as "failed citizens" who are "a drain on scarce resources" (Cooper 2016, 185; see also Farrell 2011). This is why certain kinds of – what Charlotte Cooper calls – "gentrified" fat activism, like fat positivity, are not helping the aims of fat activism. These forms of activism don't fight for the respect and value of *all* fat bodies – just those that are good and compliant. Thus, gentrified fat activism marginalizes "those who are superfat, unfit, unhealthy, or chronically ill" and "[n]ot coincidentally, these are also people with the lowest socioeconomic status" (Ibid.).[9]

3.3. The Significance of Fat Activist Testimonies

Building on my last criticism, my final concern with previous philosophical accounts is that, as implied from the discussion above, they generally ignore the interests and testimonies of fat activists. White feminist scholars have focused primarily on certain kinds of non-fat women who were unhappy with their bodies due to unrealistic body expectations. The women often being described in this literature are women with immense body privilege – they don't have problems sitting at desks, finding clothing that fits them, or getting substandard medical treatment because of their size. This criticism has surfaced recently in popular culture with the rise of the body positivity movement. The body positivity movement is more concerned with non-fat or semi-fat (e.g., "Lane Bryant Fat") white women and focuses on encouraging people to have self-compassion for their bodies. For example, the body positivity movement has been a way to encourage women to show more compassion toward their postpartum bodies or their aging bodies. The goal of the body positivity movement is to improve people's well-being by healing the relationship they have with their own body. Fat acceptance, however, is a political movement that believes body culture needs to be accepting of all fat bodies – its goal is justice for *all* fat bodies.

Another important feature of fat activism is the historical and present role that *queerness* plays. The fat liberation movement "established an analysis of fat oppression based on gender

[9] Cooper also goes on to argue that gentrified fat activism "precludes the development of rich alliances between fat and disabled people" (Cooper 2016, 187). This is a problem because she and Meleo-Erwin (2012) believe that "stronger, more purposeful alliances with disability struggles may help fat activism develop a more critical politics of embodiment and more effective challenges to healthism" (389). I will build on these points in chapter four.

and radical lesbian identity" and in response to the idea that fat hatred is a component of patriarchy (Cooper 2016, 120). Fat justice scholars have continued to build on these foundational ideas and argued that "compulsory heteronormativity works to regulate fat bodies and subjects" (Wykes 2014, 1) by enforcing bodies to comply with the heterosexual gender norms informed by patriarchal values. Fat activists and justice scholars have thus argued in favor of *queering* fat and fat activism (e.g., see Pausé, Wykes, and Murray 2014). *Queerness*, however, is not just a description of a person's sexuality or gender identity, it is also a mode of critical inquiry. Because anti-fatness has been used in ways that naturalize and justify pre-existing social inequalities (e.g., sexism, ableism, classism, and racism), queering fat attempts to challenge and disrupt (i.e., queer) dominant conceptions heterosexuality, able-bodiedness, whiteness, middle-classness, and slimness. In this way, fat activism is moving towards greater inclusiveness, which was sometimes lacking in even previous interdisciplinary frameworks of fat oppression.

Given the ways in which previous accounts of fat oppression have fallen short, in what follows I will argue that the missing components of previous accounts can be best captured by understanding fat oppression through the lens of cultural imperialism.

4. Fat Oppression as a Form of Cultural Imperialism

Cultural imperialism is the experience in which a social group is (1) stereotyped in a way that confines its members to an identity that is attached in some way to their bodies, and (2) the group's embodied perspective fails to be recognized and/or valued in the dominant culture (Young 1990). The dominant culture imposes its own perspectives and interpretations on the oppressed group because it is assumed to be representative of humanity and impartial and therefore, incontestable (Ibid.). But as a result of this "impartial" perspective, the identities of marginalized and powerless social groups are reconstructed in ways that often stereotype their members in ways that are thought to justify their inferiority.

Below, I will discuss what I take to be three central and universal features of the form of oppression described as cultural imperialism (Young 1990). After discussing these three features, I will then describe one final feature that does not apply to all cases of cultural imperialism, but does apply to cases of sexism, racism, classism, cis- and hetero- normativism, and sizeism in the United States.[10]

[10] Other features of cultural imperialism will be discussed throughout the dissertation and some that will be discussed in this chapter will be expanded on in the following chapters.

4.1. The Dominant Narrative

The driving force behind cultural imperialism is what I will call the dominant narrative.[11] The dominant narrative can also be understood as a "one subject position" that determines what society as a whole should value and as a result, judges what is wrong or unacceptable (Young 1990, 147). In the nineteenth-century, ideals of beauty and health were determined by white bourgeois men who endorsed self-control and rationality (Young 1990). This perspective made it the case that beauty involved "a disembodied, desexualized, *unfleshy* aesthetic" – and that in bodies, "light-colored hair and skin, and *slenderness*" were the ideal (Ibid., 129, emphasis added).

The interests and values of the dominant culture have been shown to influence narratives surrounding disability, sexuality, race, class, and gender (Young 1990; Okin 1999; Wendell 1996; Du Bois 2016/1903; Bettcher 2014). At the turn of the nineteenth century, modern scientific discourse attempted to justify these dominant and stigmatizing narratives about marginalized social groups. Fatness encountered a similar problem.

The dominant narrative of fatness has also come to be medicalized and pathologized.[12] This is evident in the words we use to describe bodies. Words like "obese," "morbidly obese," "overweight," and "normal weight" are used to describe the fat body within the dominant narrative – they are used to describe bodies that are sick, diseased, unhealthy and also bodies that are "normal" or acceptable. This narrative, though clearly normative, is viewed as impartial because it (purportedly) derives from science-based reasoning and experimentation. As a result, fat activists face much resistance when attempting to fight against this dominant perspective of fatness. Even though the science-based reasoning reinforces stereotypes about people in larger bodies being lazy, gluttonous, incompetent, etc., it is viewed as accurate and justified in light of what is taken to be firm medical evidence. Because our society places so much trust in science, this source of knowledge is prioritized over the experiences and testimonies of marginalized people.

[11] I will also be using the phrases "dominant narrative" and "dominant perspective" interchangeably throughout the dissertation.

[12] Although Young does talk about people in larger bodies once when giving examples of bodies that are typically viewed as "drab, ugly, loathsome, or fearful" (1990, 123-124).

4.2. Epistemic Injustice[13]

People whose bodies or experiences do not comply with the dominant narrative are nevertheless valued and judged through this lens, which affects their ability to be viewed as credible knowers (Fricker 2007; Young 1990). For example, Kristie Dotson points out (referencing Patricia Collin's work), Black women are frequently perceived as "mammies, matriarchs, welfare mothers, and/or whores," and regardless of whether these stereotypes are accurate, they impede Black women's capacities to be recognized as competent knowers (Dotson 2011, 242-243). This may lead a Black woman to feel invisible – that her own embodied perspective and identity is overlooked – as a result of being perceived in a stereotypical way.

Indeed, it is common for members of oppressed groups to be made to feel invisible by the reactions people have toward their bodies. These reactions may include "avoidance, aversion, expressions of nervousness, condescension, and stereotyping" (Young 1990, 133). However, what is strange about the effects of cultural imperialism is that while feeling invisible, not taken seriously, or demeaned (e.g., via epistemic injustice) one can also simultaneously feel marked out as Other (i.e., stigmatized) (Young 1990; Dotson 2011). In response to such behaviors and reactions, members of oppressed groups cannot respond to or "check their perceptions against those of others" for fear that they will be even further withdrawn from public contexts or cause social disruption (Young 1990, 134). Those who experience oppression in the form of cultural imperialism often find their audience reluctant or unable to accept or even recognize their perspective, and as a result might feel the need to paraphrase, shorten, or suppress their testimonies.[14] However, when members of the oppressed group decide to speak out against the oppression, they are often believed to be "overreacting" or "misperceiving the situation" (Ibid., 134; see also McKinnon 2017).

This situation occurs in the experiences of fat activists – who are simply trying to defend their right to live unapologetically and peacefully in their fat bodies – when their efforts are misconstrued as "glamorizing," "promoting," or "glorifying" obesity, or "encouraging unhealthy lifestyles" (Mahdawi 2017, Dionne 2019). People who misconstrue the message behind the fat acceptance movement are not listening to the testimonies of fat activists, are interpreting their testimonies through the lens of what they believe is clear evidence about the unhealthiness of fat,

[13] Chapter three is dedicated to discussing the various ways in which people in larger bodies experience epistemic injustice, and for that reason, I will not go into much detail here.
[14] Kristie Dotson might consider this a case of "testimonial smothering" (2011, 244).

are responding out of fear of what could happen if the movement gained some momentum, or are intentionally plastering over these narratives with problematic claims. People who publicly misconstrue the fat acceptance movement do so in a way that makes the movement appear implausible and easily refutable. In this way, the movement is perceived through the lens of the dominant narrative.

Another obstacle faced by the fat acceptance movement is that its message got confused with that of the body positivity movement. Body positivity, unlike fat acceptance, focuses more on encouraging people to have more self-compassion when it comes to things like cellulite, postpartum bodies, or the "belly rolls" that appear when sitting down, etc. Fat activism is not merely about finding clothes that fit and loving your body. It is this misconception of fat activism that makes fat activists, like Charlotte Cooper, believe that fat activism has been "'gentrified' and made more palatable to mainstream society…via plus-size 'fatshion' industry and generic feel-good calls for 'body positivity'" (Woolner 2016). Fat activism, for Cooper, is a *political* movement that "is hard fought for and emerges through risk-taking, sharing ideas, believing in the value of your own weird and wild experience" (Ibid.).

4.3. Internalized Oppression and Double Consciousness

Though subordinate groups are expected to assimilate to the dominant culture, group differences nonetheless exist, and the incompatibility between the standards of the dominant culture and how one is viewed by the dominant culture often results in an internalization of oppression norms, and the experience of double consciousness (DuBois 2016/1903; Bartky 1990). Given the inescapable and disheartening experiences that people in larger bodies endure, it is no wonder that many have come to *internalize* their oppression. Fat oppression, like racism, sexism, homophobia, ageism, and ableism, is "partly structured by abjection, an involuntary, unconscious judgment of ugliness and loathing" (Young, 145). As a result of being abject, members of the oppressed group will often not be able to fully and un-self-consciously be themselves in public settings because they will always be consciously (or subconsciously) trying to assimilate into the dominant culture that requires them to "suppress the expressiveness of their bodies" (Ibid., 140-141). In other words, people in larger bodies are rarely able to forget their group membership out in public because "the behavior and reactions of others call them back to it" – making it very difficult for them to separate themselves from the stereotypes associated with their bodies (Ibid., 123).

Because of internalized oppression, even members of oppressed groups may enact these "symptoms of fear, aversion, or devaluation toward members in their own groups and other oppressed groups" (Young, 145), using the dominant norms to shape their own judgment. The dominant culture or narrative does not just shape the views of those in privileged positions – it permeates society and affects us all.

Internalizing one's oppression makes way for experiencing what W.E.B. DuBois (2016/1903) calls "double consciousness." Even though people in larger bodies *know* on some level that they are good, hard-working, and upright citizens who deserve respect, they nonetheless also view themselves through the eyes of dominant culture. This double consciousness creates anguish. As Lindy West puts it, people in larger bodies "know they're fat and that the rest of the world thinks they're disgusting," and they may also come to believe this on some level (2016, 95). For example, Virgie Tovar writes: "I had internalized fat phobia so deeply that I believed my life wasn't worth living if I wasn't going to someday transform into a thin person" (Tovar 2018, Kindle edition). Anti-fatness is so pervasive that people in larger bodies have difficulty accepting and loving their own bodies because society tells them they are repulsive and unhealthy. Unlike other kinds of social identities that are linked to oppression, fatness is believed to be a mutable characteristic, and because of this, people in larger bodies are told and often believe that they are responsible for their suffering – if they just tried a little harder to lose weight, they could be respected, valued, and loved. Not only does this assumption wrongly connect body size and well-being, but it also assumes that weight loss is fully within individual control. Yet, drastic intentional weight loss is rarely ever maintained, if even achieved.[15] Despite these statistics, people in larger bodies continue to be blamed for their weight, which only intensifies feelings of self-loathing. For example, Lindy West writes: "I have wanted to change this body *my whole life*. I have never wanted anything as much as I have wanted a new body…I always thought that some day—*when I finally stop failing*—I will become smaller, and when I become smaller literally *everything* will get better!" (West 98, emphasis added).

[15] See the following chapter for more on this.

4.4. Developing and Maintaining a Culture and Pride

Despite these negative experiences that accompany being the target group for cultural imperialism, as a result of being stereotyped and marked out as Other, some marginalized groups may eventually develop and perpetuate a culture of their own making, thereby helping them to develop a positive sense of self and the possibility for self-development and flourishing. Although people within the group may experience some shame for not assimilating to the allegedly "neutral" standards of society, as a group, these individuals may also cultivate a "special affinity for others in the group" and this group identification may become a desirable part of who they are (Young 1990, 47). This explains the emergence of social activists within various oppressed groups (e.g., feminists, LGBTQ+ activists, disability activists, Black Lives Matter activists). Rather than feeling ashamed for not perfectly assimilating into the dominant culture, these communities have learned to appreciate and promote their unique experiences and interests. This, in turn, becomes a positive form of resistance against the prevailing social meanings that constrain their self-development and expression.

Fat pride requires fat people to share the "complexities and contradictions" of their experiences being fat (Cooper 1998). Only when diverse opinions and perspectives of the fat experience are shared, and when the dominant understanding of fatness as an unhealthy or even a shameful embodiment is publicly rejected, can a revolution begin. This is to say that the aim of fat activism (or fat pride) is to encourage public discourse about how it feels to be fat in our world, the complex experiences of fat people, and how fatness ought to be perceived. Fat activism encourages the diverse opinions and perspectives of all fat people from all backgrounds and walks of life to "enable fat people to develop a realistic awareness of fat rights issues" (Cooper 1998, 173). The more fat people share their experiences and perspectives, the better we understand the complexity of fat rights issues, and the more force their message will have.

5. Objection: Is It *Really* Oppression?

Though I think that many would agree that people in larger bodies are unfairly *discriminated* against, I can imagine that many would still hesitate to call this group of individuals *oppressed*. Some social groups that are typically viewed as oppressed include people of color, women, disabled people, and people in the trans and queer community. What distinguishes these groups of individuals from people in larger bodies is that they are generally

not held *responsible* for their way of being in the world.[16] People in larger bodies are not only thought to be causally responsible for their body size but also perceived as, at least to some degree, unhealthy. Therefore, many may think it is inappropriate to call a group of individuals oppressed if they to some extent *chose* to live in an unhealthy body.

The response to this objection is two-fold. The first part of the response requires a clarification of what I mean by "oppression." The second part of the response will challenge dominant beliefs about health and fatness. Namely, if people are hesitant to call people in larger bodies oppressed simply because they have *chosen* to live in an *unhealthy* body, then, again, it seems like our concern about fatness really comes down to a *concern about health* and what we presume *causes* poor health in relation to fatness. In the following chapter I will address this latter concern that I think most people have. For now, I will clarify what I mean by oppression and why people in larger bodies are oppressed while smokers should not be considered oppressed.

When people are oppressed their options and opportunities are severely restricted because oppression is structural (Frye 1983; Young 1990). Oppression need not be a result of a conscious and intentional oppressor limiting a person's options; rather, it is the result of injustice that manifests itself in many different aspects of a person's life and in sometimes subtly connected ways. The lives of oppressed people are "confined and shaped by forces and barriers which are not accidental or occasional…but are systematically related to each other in such a way as to…restrict or penalize motion in any direction" (Frye 1983, 32). In other words, people who are oppressed experience a "double bind" in that whatever action they take, they can't win. People in larger bodies fit this description because regardless of what choices they make – e.g., to try to lose weight or to try to just ignore anti-fat sentiments – they are restricted or penalized. Choosing to ignore anti-fat sentiments from others will most likely take a toll on a person's mental and physical well-being (Puhl and Heurer 2010). Those who choose to try to lose weight to avoid anti-fat sentiments will likely still run into obstacles. People in larger bodies have chronicled various examples of harassment, and sometimes violence, they experience when trying to exercise in a gym or outside and when eating foods that are thought to be healthy, like salads (e.g., see Gay 2017; Laymon 2018; Solovay 2000). For example, they experience constant

[16] This isn't as true for queer folks and especially not the case for trans folks. These groups of individuals are still believed to have some "control" over their sexuality and gender identification.

monitoring and being given unsolicited weight loss advice or words of encouragement – sending the message that they don't belong there. Even in their attempts to change their bodies to conform to body norms, they are harassed, ridiculed, or may be victims of physical violence (Solovay 2000).

Given that a large majority of smokers started smoking because of peer pressure, one may think that smokers who (1) were peer pressured to start smoking, (2) haven't successfully overcome their addiction to nicotine, and (3) are experiencing discrimination and stigma, are oppressed. While smoking was once glamorized by the media and pop culture (and sometimes still is), it is increasingly being stigmatized as the percentage of smokers decreases. Additionally, similar to people in larger bodies who attempt weight loss, the percentage of smokers who successfully quit smoking is modest, and of the approximately 55% of smokers who have tried to quit in the past year ("Smoking Cessation: Fast Facts" 2022), may experience *internalized shame* (O'Connor et al. 2017). The internalized shame is significantly higher in smokers who are planning to quit within the next 6 months (Ibid.), and in 2015, approximately 68% of smokers said they were trying to quit (CDC). This shame smokers feel also, like with weight loss attempts, comes with feelings of inferiority due to a perceived lack of willpower – a lack of willpower to say no to smoking in the face of peer pressure and a lack of willpower to quit.

One distinguishing factor between smokers and people in larger bodies is that should smokers try to stop smoking, while it may be difficult and may trigger shame if quitting is unsuccessful, they will not be exposed to ridicule or harassment in their efforts to quit smoking – in fact, they may actually experience less bullying and discrimination by doing this. Should smokers continue to smoke, they may be discriminated against – by means of smoking bans, for example – and experience bullying as a result, but this is no comparison to the harassment that people in larger bodies experience. This is in part because smokers can "pass" (to varying degrees) as non-smokers so long as they are not holding a cigarette but more importantly, the stigma attached to smokers' bodies is nothing compared to that of fat bodies.

Another major factor that distinguishes the experiences of people in larger bodies and smokers is that the stigma of larger-bodied persons is attached to their body size (from which we presume they don't eat healthy or exercise) while the stigma of smokers is attached to the act of smoking. This is important because simply living in a larger body does not harm anyone, but smoking has been shown to negatively affect the health of nonsmokers. The problem with

smoking is that, were it allowed everywhere, it would not only affect the health of the smoker, but also others through secondhand and thirdhand smoke. Secondhand smoke has shown to increase lung cancer risk by about 20 percent among nonsmokers ("What Are the Effects of Secondhand and Thirdhand Tobacco Smoke?" n.d.). Research has shown that the chemicals in thirdhand smoke includes not only nicotine but also carcinogens such as formaldehyde, which can build up or get embedded on various kinds of surfaces over time and can remain on the surfaces for months after smoking has stopped, which can be particularly harmful for children should they somehow ingest it ("The Dangers of Thirdhand Smoke" n.d.).

This leads to my second point, which will be expanded on in the following chapter. Smoking, unlike fatness, is clearly bad for people's health – it is *causally* responsible for things like lung disease and coronary heart disease and also negatively affects the health of nonsmokers ("Health Effects of Smoking and Tobacco Use" 2022). There is no clear causal connection between fatness and poor health, though that connection is widely presumed to exist (Mann et al. 2007, Howard et al. 2006, Gardner et al. 2007). Also, one's being fat does not cause the deterioration of other people's health. I have already begun making a case for arguing that fatness is likely produced by social determinants such as lack of access to food and safe neighborhoods, stress, and anti-fat bias and discrimination (Parker et al. 2022; Kendall 2020; Nash 2021; Blackmoon 2020). In the following chapter, I will go into more detail as to why we should not assume that fatness is unhealthy and why, if we are truly concerned about health, we should not be recommending weight loss.

6. Conclusion

I have argued that fat people are oppressed via cultural imperialism. To make this argument, I described what I call oppression and why the experiences of people in larger bodies fit the description. I also explained how previous philosophers have fallen short of offering an appropriate explanation of the kind of oppression that is taking place – they have either: (1) provided a limited historical scope of the problem, thereby ignoring the role race played in the development of anti-fatness, (2) ignored the ways in which other social groups besides cis-het white and middle- or upper-class women are harmed or oppressed by fat oppression, (3) underemphasized the role that the pursuit of health has played in perpetuating fat oppression, and/or (4) ignored the testimonies of fat activists who have a much clearer sense of what needs to

be done for liberation. I then explained what cultural imperialism is and why we should think that fat oppression is being perpetuated via cultural imperialism. And finally, I began a response to a potential objection that people in larger bodies should not be considered oppressed because they have chosen to live in a body that is unhealthy.

In the following chapter, I will finish addressing what I call the concern for health objection. I will explain why if we are actually concerned about people's *health* (though I don't think many people really are), recommending weight loss is not the answer.

Chapter 2: The Medical Model of "Obesity" and the Values Behind the Guise of Health[17]

One morning in June of 1998, twenty-nine million Americans with average figures woke up "overweight." This was not a coincidence or a freak accident. It was not due to a nationwide eating contest or protest against exercise. Rather, it was a policy decision by the National Institutes of Health (NIH) to lower the maximum limit for "normal" weight on the Body Mass Index (BMI) scale from 27.8 for men and 27.3 for women to 25 for both men and women (Saguy 2012). These people woke up one day "with a presumed increased risk of type 2 diabetes, hypertension, and atherosclerosis and a government prescription for weight loss" despite the fact that none of them had gained any weight (Bacon 2010, 152).

The NIH's decision relied on a 1995 World Health Organization (WHO) report (Bacon 2010, Saguy 2012, Oliver 2006). The WHO report was written with the help of the International Obesity Task Force (IOTF), an organization whose first mission was to get the lower BMI standards imposed (Oliver 2006), a mission that was not scientifically motivated by any new discoveries in obesity (Squires 1998). The change was controversial. Some scientists fought the lowering of BMI standards because the science was inconclusive about what weight ranges should be considered healthy – some studies found no relationship between being overweight and an increased risk of mortality while others did, and some studies even found an *inverse* relationship (Troiano et al. 1996). That is, studies in the WHO report suggested that BMI standards should be raised, not lowered (Troiano et al. 1996, Saguy 2012, Oliver 2006, Bacon 2010). Other scientists, however, were motivated by the studies that found evidence of viewing being overweight as a risk factor for mortality. IOTF members leading the charge had the most to gain from lowering the BMI thresholds, given that "seven of the nine members on the . . . [IOTF] were directors of weight-loss clinics, and most had multiple financial relationships with private industry" (Bacon 2010, 152).[18] Indeed, the IOTF was at the time primarily funded by two

[17] An almost identical version of this chapter has already been published – see Mehl (2023b).

[18] For example, Xavier Pi-Sunyer was elected chair of the NIH task force on obesity in 1995 while simultaneously serving as a member on the WHO panel. During this time, Pi-Sunyer also served on the advisory board or was a paid consultant to several diet and pharmaceutical industries like Wyeth-Ayerst labs (the creators of the notoriously dangerous diet drug Fen-Phen that ended up causing heart valve damage), Knoll, Eli Lilly Pharmaceuticals, Genetechn, Hoffman-La Roche, Neurogen, and Weight Watchers International (Oliver 2006).

weight-loss companies: Hoffman-La Roche (the maker of the weight-loss drug Xenical) and Abbott Laboratories (the maker of the weight-loss drug Meridia) (Oliver 2006).

This policy change coincidentally occurred around the same time as the "Phen-Fen" controversy, which resulted in one of the costliest healthcare liability settlements in history. These diet pills were found to be linked to serious, life-threatening side effects like heart valve disease and primary pulmonary hypertension. The FDA had approved these diet pills despite recognized medical risks on the basis of the argument that obesity is a rapidly growing, serious health concern, and the risks of obesity are greater than the risks of the drugs. Obesity experts, pharmacists and family doctors went along with this argument (Johannes 1997; Kolata 1997; Langreth 1997; Pollack 2012; Mundy 2001). A similar argument has also been used to encourage some patients to undergo gastric bypass surgery (i.e., the risks of obesity outweigh the risks of the surgery). Though perioperative mortality rates have dramatically decreased since the early 2000s (e.g., see Flum et al. 2005), there is still risk of mortality and short- and long-term adverse outcomes with gastric bypass surgery (Arterburn et al. 2020; Roux and Heneghan 2018). The message in both cases appears to be that anything is better than being obese (Shermer 1983).

In this chapter, I argue that these types of decisions – decisions that relied on the illegitimate use of values in science and science policy – played an essential role in establishing what I call the *medical model*, or the dominant narrative around fatness. Despite problematic origins, the medical model has continued to play a role in obesity research in a self-vindicating way that conflicts with both the epistemic and social aims of research. The story of how BMI thresholds were lowered, for instance, demonstrates how non-epistemic values have illegitimately shaped the way we have come to understand obesity, and the assumptions of the medical model have preserved this illegitimately crafted concept of obesity. Researchers and policymakers made a deliberate choice to lower the "normal" weight threshold despite conflicting evidence thereby raising the bar for what society deems a "healthy body." However, given the ways in which people in larger bodies are already discriminated against (e.g., in job opportunities and health care services)[19] and endure emotional and physical degeneration as a result of this discrimination (Tomiyama et al. 2014, 2018; Vadiveloo and Mattei 2017; Vartanian

[19] See, for example, Bellizzi and Hasty (1998), Giel et al. (2010), Vanhove and Gordon (2014), Tirosh (2012) and Roehling (2006) on ways in which people in larger bodies are discriminated against on the job market or in the workplace. See Sabin et al. (2012) Schwartz et al. (2003) on the prevalence in which doctors and obesity experts employ both implicit and explicit anti-fat biases.

2008), this controversial decision was not in people's best interest, contrary to what most people may think. In other words, the social aim of obesity research – i.e., to improve the *health* and well-being of people in larger bodies[20] – is not being fulfilled.

The problem with obesity research is not that values have influenced the research but rather, that the wrong kinds of values – values that do not further the social or epistemic aims of obesity research – have done so by means of the *medical model of fatness*. The medical model is what I understand to be the *dominant narrative* of fatness. It has perpetuated fat oppression through contemporary society's seemingly legitimate pursuit of the cultural value of *health*, which is generally thought to be antithetical to fatness. The medical model is made up of three main dogmatic assumptions that defend the standard way of conceiving bodies and more specifically, obesity (Gordon 2020; Harrop 2019; Saguy 2012; Gard and Wright 2004). These three dogmas are: (1) Other things being equal and above a certain threshold, the more one weighs, the unhealthier one is (or vice versa);[21] (2) An "overweight" or "obese" body is to some degree inherently unhealthy; and (3) People who are "overweight" or "obese" are so because they do not eat properly and/or do not exercise enough. This is not an exhaustive list of assumptions, but any account of obesity that upholds at least one of these dogmas would qualify as drawing upon the medical model under my view. It is these types of assumptions that generally sustain the concern for health objection in response to the fat acceptance movement.

In this chapter, I will first provide a brief overview of the aims approach and lay out what I take to be a rather uncontroversial understanding of the aims of obesity research (§2). I will then identify epistemic issues besetting the medical model of fatness, which affect both how it was established (§3) and how it maintains itself in the face of recalcitrant evidence (§4). Furthermore, given that obesity research is intended to improve the health of people in larger bodies, the medical model functions in a way that conflicts with this social aim. Finally, I will

[20] Though the terms "overweight" and "obese," are often used to describe people in larger bodies, fat activists consider it a slur (Chastain 2020). For that reason, I will often use the phrase "people in larger bodies." However, when explaining beliefs, assumptions, or ideas made by obesity researchers (including my characterization of the medical model), I will use the language that researchers use for clarity and accuracy (in scare quotes). The distinction, for example, between "overweight" and "obese" matter for accurately reporting obesity research. I will also refer to the "condition" as "obesity" and refer to the relevant kinds of research as "obesity research."

It should be noted that fat activists are reclaiming the word fat, which is taken to be a *political* identity, to contest shame, express power, and expose the limitations of the medicalized language (Cooper 2016). Should obesity researchers incorporate the perspectives and testimonies of fat activists in their research (as I recommend in §4), there may be hope for abandoning the medical model, and with it the stigmatizing language it employs.

[21] I do not think medical professionals consider people who are "underweight" to be healthier than those who are "normal weight" or heavier. This is why I add the quantifier "above a certain threshold."

explain how the concern for health objection is not a sufficient reason for perpetuating fat oppression nor is it a sufficient reason for discrediting the fat acceptance movement (§5).

1. Fulfilling the Aims of Obesity Research

Philosophers of science have argued that the scientific methods used in research should be chosen with regard to the aims of research (e.g., Intemann 2015; Brown 2020; Potochnik 2015). This is in part because methods may sometimes "carry value commitments" (Crasnow 2020). In the context of obesity research, I argue that the medical model has been relied upon to justify certain methodological choices that have in turn prevented researchers from achieving their purported epistemic and social aims. As I show, the medical model carries problematic value commitments regarding obesity.

The aims of research can sometimes be made apparent by the language researchers use. Certain scientific hypotheses and goals are value-laden in themselves because they contain normative concepts (Intemann 2015). In the context of climate change, hypotheses and research questions may contain words – like "dangerous," "vulnerabilities," "losses" – that we take to be important in that they bear on human (and environmental) flourishing (Ibid., 223). In the context of obesity research, words such as "health," "harmful," "unhealthy," "deadly," "disease" are pervasive and obesity researchers use them to motivate their projects – projects that often assume obesity to be a serious and life-threatening disease. This language makes it particularly difficult to separate the strictly epistemic aims of obesity research from the strictly non-epistemic aims.[22] But even if research questions or hypotheses do not contain normative concepts, how a phenomenon is measured or conceived depends on *why* we want the information, which will often require appealing to social and ethical value judgments (Intemann 2015).

One could say that the general aim of obesity research is something like: using science-based research to understand the nature of obesity in order to promote health and well-being. If we break this statement into parts, we can see that one specific goal of obesity research is to

[22] As Alexandrova (2017) argues, concepts like "health" and "well-being" are partly normative and partly factual in that their definitions and measurements depend on moral claims about what is required to be healthy or have adequate levels of well-being. Thus, many claims found in obesity research (and the medical model dogmas) may be considered what Alexandrova calls "mixed claims" in that these statements are essentially "scientific hypotheses that rely on both factual and normative categories" (Ibid.,79). Even the terms "obesity" and "overweight" are in themselves value-laden. Measurements may not be value-laden on their own and without reference to some kind of ranking or classification system, but when such measurements are used to categorize bodies as diseased, non-epistemic values are involved.

generate accurate beliefs about the biological processes happening in the body, specifically as it relates to the accumulation of adipose tissue (i.e., an epistemic aim). However, this goal matters as much as it does because we need this information in order to carry out another goal – giving appropriate advice to people who are "overweight" or are susceptible to becoming "overweight" (i.e., a non-epistemic aim). In other words, researchers care about generating accurate beliefs about obesity to help those who are most affected (i.e., the stakeholders).

Given that obesity research has clear social, political, and economic implications for many people in our society, it is understandable that we should "want our public policy making to be democratically legitimate, accountable to the public, and representative of the range of our values" (Brown 2020, 73). This requires that researchers prioritize values such as social justice, diversity, inclusion, and equality in their research that informs public policy. Furthermore, since certain groups of people are disproportionately and systemically affected by obesity research and its recommendations for public policy (e.g., people in larger bodies, people of color, impoverished communities),[23] obesity research needs to place more emphasis on the interests and participation of these stakeholders who are most affected and particularly, those who are most vulnerable (Brown 2020; Intemann 2015). In addition, ensuring that a broad range of criticism is carefully considered will help to ensure that any scientific consensus arises not as a result of economic or political power nor through the exclusion of other perspectives but rather, as "a result of critical dialogue in which all relevant perspectives are represented" (Longino 2002, 131). This means that we ought to incorporate not only the views of people who are most impacted by this research (e.g., people in larger bodies), but also people who also have strong criticisms against the research (e.g., fat activists and fat justice scholars).

The problem with obesity research is not that values are present but rather, that these values are often "uncritically accepted without justification by a rather monolithic group of those practicing science" (Intemann 2017, 131; see also Longino 1990, 2002). Researchers may not question their research goals, the ways they collect data, or the models that they use because they may have, for instance, grown accustomed to following a precedent and been unknowingly influenced by what the scientific community takes to be valuable about what they are studying.[24]

[23] See, for example, Puhl and Heurer (2010) and Dinour et al. (2007) for discussions on how these populations are disproportionately affected by obesity research.

[24] For example, if a conservation biologist is gathering data to determine if a species is endangered, then she may interpret the count in a way that would justify imposing regulations on hunting or development (Intemann 2015).

Obesity research has focused on the ways in which obesity is correlated with poor health outcomes and on the most effective interventions because of the heightened concerns tied to the medical model. Decisions about what statistical methods to use, what to take as data, how to collect and interpret the data, which confounding factors to account for, etc. do not simply rely on epistemic (or cognitive) values like logical consistency, simplicity, testability, and predictive accuracy, but also on non-epistemic (or noncognitive) values, including researchers' goals, interests, and responsibilities, as well as broader cultural norms. In this way, research can falter in relation to its epistemic aims by failing to explore other worthwhile research questions, recognize broader ranges of evidence, and adopt other conceptual schemes.

Incorporating values like justice, diversity, and inclusion has the potential to improve both the social and epistemic aims of obesity research. Implementing non-epistemic values such as these elevates the interests and perspectives of stakeholders and what they take to be valuable about the research, which has the potential to make the research most epistemically fruitful (Anderson 2004). When incorporating diverse perspectives and perspectives of stakeholders, the norms of inquiry and what is taken to be valuable are not only questioned, but questioned by the people who have the most to lose (Brown 2020).

2. Definitions, Categories, and Choices that Established the Medical Model

In this section, I argue that the medical model was established on the basis of insufficient evidence. I will show how each dogma was established by an unforced choice and how values illegitimately shaped that choice. I am *not* criticizing the way the evidence bears on certain hypotheses. Rather, I am calling attention to the ways that values and assumptions have played a role in promoting an overly narrow and pathologized perspective of fatness in face of conflicting evidence and in ways that impede the social aims of obesity research.[25] In §3, I will demonstrate

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The biologist's value judgements are not used to determine how many species exist, but they may be used to determine the conceptual scheme that will be used to interpret the data. For instance, decisions about what to count as members of a species and what total number of a species is considered troubling will depend on the conceptual scheme employed.

[25] In this chapter, I am criticizing the choice of model that provides the background assumptions against which we interpret evidence, which is different from criticizing whether or not the evidence – given the assumption of one or another model – supports a hypothesis. In this section, I provide some historical and educational background on why the medical community adopted the medical model of fatness and the ways values illegitimately influenced this decision, particularly given the social aims of obesity research. I thank an anonymous reviewer for urging me to clarify this point, and I thank Paul Franco and Rose Nozick for helping me formulate it.

ways in which obesity researchers have relied on these assumptions in their research, thereby affecting their methodological choices.

2.1. Dogma 1: The more a person weighs, the unhealthier they are (beyond a certain threshold)

In order for the first dogma of the medical model to be established, or for there to be a neutral and quantifiable way to determine who should be considered unhealthy, an agreed upon unit of measurement for body weight/size was required. Before the controversy of determining what BMI ranges should be considered "overweight" or "obese," there was (and still is) controversy surrounding the decision to rely on the BMI at all. Part of the controversy stems from the fact that the calculation for BMI – developed by a Belgian astronomer, Adolphe Quetelet – was designed merely to classify the population for the purpose of a statistical experiment (Oliver 2005).

The Quetelet index calculations were later used by health insurance companies to determine which insured populations had the most desirable or least desirable ratios of weight and height in respect to their mortality rates (Nuttall 2015), despite the fact that Quetelet did not use BMI to make predictions about an individual's level of disease, health, or likelihood of mortality (Oliver 2005). Like Quetelet's sample – i.e., an exclusively white, European group – the data used by health insurance companies on mortality risk and BMI were based almost exclusively on wealthy white men. As a result of these historical methodological choices, BMI fails to account for variations in race/ethnicity, age, gender. It also fails to account for variations in body composition – i.e., proportions of fat, muscle, and bone mass (Gard and Wright 2005, Campos 2004). For example, many professional athletes – despite their low body fat and/or high levels of cardiorespiratory fitness – are considered "overweight" and even "obese" by BMI standards because of the amount of muscle they have on their bodies. BMI calculations also distort the fat assessment of women, given that women are statistically shorter and have higher levels of adipose tissue than men (Gard and Wright 2005).

BMI is not just a poor measure of body fat; it is also a poor measure of health (Tomiyama et al. 2016). Nevertheless, BMI is being used as a "risk-prediction tool" for health (Glassman 2022). If people are considered "obese" or even "overweight" on the BMI scale, it is assumed that they are less healthy and at an increased risk of developing certain illnesses or diseases. However, research on the increased susceptibility of people in larger bodies to disease and

mortality is inconclusive (Bacon 2010, Lavie 2014). BMI is also an inaccurate tool for measuring the health of a *diverse* group of individuals. For example, while black women in general have higher BMIs than white women, they actually have lower mortality rates at a given BMI (Campos 2004, Strings 2019). As age increases, the link between obesity and mortality diminishes significantly and has even been said to be nonexistent in some studies (Heiat et al. 2001; Bender et al. 1999). Additionally, data from a larger and more diverse sample group have shown that people who fall in the "overweight" BMI category have the lowest mortality risk and there is only a slightly increased risk of mortality among "obese" people (Flegal et al. 2005).[26] When making predictions about people's health based on their BMI, the predictions need to rely on the distribution curve for the relevant demographic or run the risk of making poor predictions about the health of certain social groups.[27]

Despite these weaknesses, BMI continues to be used widely to measure body fat and gauge the health of all individuals, and as a result, the legitimacy of BMI to accurately measure body fat and health has been assumed in obesity research methodology and in public health approaches to obesity. In the 1990s the World Health Organization (WHO) decided to use BMI to categorize different body weights and heights into groups such as "underweight," "normal weight," "overweight" (sometimes called "pre-obese"), and "obese." Other government health agencies, like the NIH and Centers for Disease Control and Prevention (CDC), also rely heavily on BMI as the primary indicator of weight, health, and mortality risk of Americans. While some public health agencies and researchers recognize that BMI does not accurately calculate body fat or accurately predict health,[28] it is still widely used for these purposes because it is easy to calculate and quantifiable (Jutel 2017). While being easy to calculate and quantifiable could count as legitimate reasons to choose one method of measurement over another, following the aims approach, the method for measuring adiposity should still satisfy our other aims – i.e.,

[26] As I will discuss in §3, an inverse relationship between body fat and risk of death has been observed across various illnesses and diseases – a phenomenon that has been called the "obesity paradox." Though obesity has been said to contribute to the development of certain diseases (e.g., cardiovascular disease), it has been argued that obesity becomes *protective against mortality* once the disease sets in (e.g., see Lavie 2014).

[27] It *may* be the case that BMI could be appropriately used to confirm a doctor's suspicions that a patient is "underweight," however, given the very small percentage of Americans who are considered underweight, this method of measurement should not be the norm. Additionally, as noted previously, dogma 1 does not extend to this category of persons.

[28] Just in the past year, there have been increasingly more articles and reports suggesting BMI is not an adequate proxy or measure for health.

generating accurate beliefs about health or at the very least, accurately measuring body fat – which BMI does not do.

2.2. Dogma 2: An overweight body is unhealthy

The second dogma of the medical model demarcates bodies that are "unhealthy" or "diseased" from those that are presumably "healthy." Though obesity has been treated as a medical condition and, more specifically, a disease, at various times in history, the justifications for doing so have been inconsistent and socially laden (Rasmussen 2019). The current obesity epidemic was arguably triggered by the work of William Dietz and Ali Mokdad in the late nineties (Oliver 2006). In 1999, Dietz along with other scientists, including Mokdad, presented obesity rates in the U.S. in a way that made obesity look more like a rapidly spreading transmittable disease than merely a form of human variation with increasing prevalence (Mokdad et al. 1999). They illustrated the growing rate of obesity with a series of color-coded maps on a PowerPoint slideshow – light blue represented the lowest obesity rates (less than 10%), dark blue represented increasing obesity rates (between 10 and 20%), and the states turned red when the obesity rate exceeded 20%. The maps showed the growth of obesity as the dates progressed from 1985 to 1999. The presentation of the data was alarming because the maps appeared to illustrate something akin to a spreading infection: "As the redness moved from one state to others nearby, it seemed to demonstrate that obesity was infecting the population with virus-like speed" (Oliver 2006, 614). The authors believed their map was an effective rhetorical tactic for convincing others that obesity was a national threat, and they were right.

Mokdad et al. (1999) has been cited over three thousand times, including by Surgeon General Dr. David Satcher in "The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity" in which he referred to obesity as an *epidemic* (Office of the Surgeon General 2001). After Mokdad et al. (1999) presented their work in various venues and made their maps publicly available on the CDC website, this framework for viewing obesity spread like wildfire despite the misleading nature of the maps (Oliver 2005).[29] Dietz and Mokdad made the

[29] We all know that obesity is not a transmittable disease, however, these maps were misleading due to the way the data was presented, making it look like obesity was a spreading infection that was migrating from state to state. What the maps actually showed was the percentage of people in each state with a BMI over 30. The real reason states like Mississippi, Alabama, and West Virginia were some of the first states to turn red was because they are located in largely rural and poor parts of the country, not because an outbreak occurred there. This data is also misleading given that states that are geographically large but have smaller populations (e.g., North Dakota) are being viewed as equivalent to those that may appear geographically small but have larger populations (e.g., Pennsylvania).

conscious choice to display obesity in a way that would attract attention by taking advantage of moderate pre-existing fears surrounding obesity (Oliver 2006). The national conversation shifted from whether obesity is linked to health issues to *what should be done* about its increasing incidence.

Although the idea of an "obesity epidemic" started in the 1990s, it wasn't until June 2013, that the American Medical Association (AMA) passed Resolution 420 and declared obesity a disease. Shortly thereafter, several other organizations followed suit. While the AMA's decision did not have any legal authority, having the nation's largest physician group make this decision certainly portrayed obesity in an alarming way. This decision, however, was made despite the objections raised by the AMA's expert committee, the Council on Science and Public Health (Greenhalgh 2015, Pollack 2013).

The expert committee argued that obesity should not be considered a disease for several reasons. First, as already discussed, the BMI calculation for determining obesity is overly simplistic and fails to reliably predict a person's level of health due to its failure to account for variations in body composition, gender, and race/ethnicity among individuals. Second, obesity does not easily fit the definition of disease: when a condition is called a disease it typically means the body's normal functioning has gone wrong, but accumulating fat is the body's normal response to a set of circumstances (e.g., stress, famine) (Brown 2015). Third, there are no specific symptoms (e.g., sleep apnea, immobility, metabolic abnormalities) that are always, or even usually, associated with obesity (Brown 2015, Greenhalgh 2015).[30] There are people in larger bodies who are metabolically healthy and have no mobility or joint issues and there are people of normal weight who suffer from metabolic abnormalities. Obesity itself has no "characteristic symptoms" – the accumulation of adipose tissue is the definition of obesity, not a symptom of obesity (AMA, Council of Scientific Affairs Report, 2012).[31]

As a result, for a state like North Dakota to turn red only 228,600 people need to have a BMI over 30, whereas Pennsylvania would need a whopping 3,840,000 people. However, by just looking at the map, when states like North Dakota turn red, it makes it appear as though a large proportion of the U.S. population is obese given that a larger proportion of the map has turned red, but this isn't the correct way to interpret the map.

[30] A report by the expert committee explains how there is no one definition of disease that encompasses all diseases accepted as such, and thus, no symptoms are dead giveaways for classifying something as a disease. A community's decision on calling something a disease has been "heavily influenced by contexts of time, place, and culture as much as scientific understanding of disease processes" (AMA, Council of Scientific Affairs Report 2012, 4).

[31] This conception of obesity has changed in recent years, as organizations like the World Obesity Federation and The Obesity Society have moved to define obesity as a disease, not as a BMI range or as the accumulation of adipose tissue. The physiological conception of obesity has become more nuanced in the past decade as a more sophisticated understanding of adipose tissue has developed (Cypess 2022).

Moreover, they recognized that viewing obesity as a disease would suggest that all people in larger bodies are unhealthy to some extent. The expert committee worried that defining one-third of Americans as diseased could lead to more reliance on costly drugs and surgery (Pollack 2013). In sum, the committee felt that recognizing obesity as a disease would not improve health outcomes – which, as previously discussed, is a central aim of obesity research (Brown 2015, Greenhalgh 2015).

Nevertheless, the AMA decided to call obesity a disease. Surprisingly, they claimed to have made this decision due to an "overabundance of clinical evidence" (AMA House of Delegates 2013, 1). Yet their own expert panel was not convinced. Clearly the available evidence was less than persuasive.

The AMA's ultimate decision relied on reasons such as: obesity contributes to other illnesses that impair bodily function; obesity is associated with symptoms such as joint pain, sleep apnea, immobility, and low self-esteem; and weight-loss from lifestyle, medical therapies, and bariatric surgery could reduce mortality and improve health (AMA House of Delegates 2013).[32] However, their list of symptoms that accompany the accumulation of body fat is seriously problematic. Consider, in particular, the symptoms of immobility and low self-esteem. A large percentage of "obese" people are mobile and have an active lifestyle. The CDC reports that 40 percent of the U.S. population is "obese" (CDC 2022), but only 11 percent of the population, for various reasons – not only due to obesity – is immobile (CDC 2023).[33] Additionally, a person may not be simply limited by their body but also by their environment – for example, small seats/desks or narrow aisles on public transportation may severely limit a person's options for movement and may deter people from trying to move.[34] Building on this point, the symptom of low self-esteem is also problematic in that it is clearly not a biological

[32] I will discuss later the controversy surrounding the AMA's claim that weight-loss from lifestyle, medical therapies, and bariatric surgery could reduce mortality and improve health. I will also discuss a phenomenon called the obesity paradox, which also calls into question the AMA's claim that obesity impairs bodily function.
[33] This isn't to say that there is no association between weight and mobility but rather, there are many people in larger bodies who are mobile and even *active*. The category "obese" consists of a wide range of body sizes and shapes. Many professional football players and basketball players, for instance, are considered "obese" and yet, they have incredible fitness capacities and are unquestionably mobile (Lavie 2014). Thus, given the number of people in larger bodies who are mobile and/or active, it doesn't seem fitting to say that immobility is a symptom of obesity.
[34] Similar arguments have been made by disability scholars to say that it is not the body itself that is disabling but rather, the environment we live in – that is, such arguments support a social model of disability (as opposed to a *medical model* of disability) (see, e.g., Oliver 1996).

effect of obesity but rather, a social effect of living in an environment that is not welcoming of people in larger bodies and therefore, should not serve as a reason to pathologize obesity.[35]

The story of how the AMA decided to classify obesity as a disease clearly echoes discussions in philosophy of medicine regarding how we should define concepts like disease and health (e.g., see Boorse 1975; Aronowitz 2001). Other scholars have used the case of obesity to motivate general discussions in philosophy of science such as: the complexities of calling certain bodily conditions a disease (e.g., Ershefsky 2009; Reznek 1987); the sociological issues around disease classification (Jutel 2017); the best models for epidemiological explanation (Broadbent 2009); and how helpful causal inferences are in helping us make predictions about the effectiveness of disease interventions (Fuller, Broadbent, and Flores 2015). For my purposes, the story is simply an example of how values illegitimately influenced decisions that led to the development of the medical model – a model that has been used in ways that further entrench the assumptions therein and does not promote democratically endorsed aims.

2.3. Dogma 3: People are overweight because they do not eat and/or exercise appropriately

The third dogma focuses on the assumption that individuals can manage their weight through eating and exercise. Because of it, individuals are often blamed (or praised) for their body size. The stigmatization of people in larger bodies has endured despite the AMA expert committee's conjecture that calling obesity a disease would reduce weight stigma (Pollack 2013). They thought that defining obesity as a disease might encourage people to view obesity as something that people do not have full control over. However, our society's fixation on how to stop the obesity epidemic sustained the belief that obesity is *curable and preventable*. The expert committee's consideration of how categorizing obesity as a disease could reduce weight stigma – an aim that would be democratically endorsed in that it would be informed by the non-epistemic values of the stakeholders – was laudable, but they failed to foresee how society's desperate

[35] I should note that as the medical understanding of obesity has become more nuanced, so too have arguments that obesity is a disease. For example, Kilov and Kilov (2019) argue that obesity meets the criteria for disease from both a naturalistic and constructivist conception of obesity. However, these authors make similar conceptual mistakes as the AMA in some cases. They too treat stigma as a harm of obesity rather than that of fatphobia. They a lso make the unlikely assumption that calling obesity a disease will improve patient outcomes. Given the prevalence of anti-fat beliefs among health care providers (Sabin et al. 2012; Schwartz et al. 2003), simply calling obesity a disease will not change the assumptions health care providers make about patients in larger bodies. I thank an anonymous reviewer for pushing me to mention how the medical understanding of obesity has become more nuanced since the AMA ruling. I would argue that the way current recommendations of healthcare providers and public health organizations are still relying on certain medical model assumptions (see §5) demonstrates that these nuanced understandings of obesity are not widely held and/or they are not as nuanced as they should be.

attempts to treat the disease would further harm the stakeholders. In fact, the AMA's decision to call obesity a disease was motivated by the medical community's desire to "advance obesity treatment and prevention," as stated in Resolution 420 (AMA House of Delegates 2013, 2; see also Brown 2015 and Mundy 2001).

Dogma 3 reflects a common belief about obesity – that it is caused by poor eating choices and inactivity. Consequently, public health organizations have been promoting healthy eating and exercise in an effort to reduce the prevalence of obesity. However, it is a common misconception that obesity is personal responsibility (Reiheld 2015) – if you are unable to achieve "normal weight," you are simply doing something wrong or are not doing enough. In other words, underlying the assumption that obesity is a personal responsibility is the belief that intentional and long-term weight-loss is *achievable*. This story is further motivated by obesity experts and healthcare providers who call attention to the National Weight Control Registry (NWCR) as proof that people can successfully lose weight and maintain their weight-loss. Though it is true that some people succeed at permanently losing weight, portraying them as role models gives others a false sense of optimism about their own potential for weight-loss and deludes healthcare professionals into believing that weight loss is a realistic goal, thus perpetuating the stigmatization of people in larger bodies (Ikeda et al. 2005). So, not only is it assumed that weight-loss is achievable but also that people who achieve weight-loss are "typical" and those who don't achieve weight-loss are atypical (Ibid.).

This assumption is allegedly defended by the long history of research suggesting that if people simply eat and/or exercise in a particular way that they will lose weight and become healthier. However, many of these studies are biased because they exclude participants who do not attend the follow-up appointments (two to five years after the diet ends) for unknown reasons. Such participants may not have attended these follow-up appointments because they had gained back the weight (Mann et al. 2007). If so, excluding them makes the diets appear more effective than they actually were. Plenty of evidence shows that most people who are able to intentionally lose weight through diet and exercise are unable to keep the weight off long-term (e.g., see Mann et al. 2007; Howard et al. 2006; Garner and Wooley 1991; Kassierer and Angell 1998). Additionally, weight-loss drugs like Redux, for example, only produce about a three percent weight-loss compared to taking a placebo, but one of the selling points from the pharmaceutical company was that "even a small weight loss was better than none" (Mundy 2001,

65). Bariatric surgery is another option for people that may result in weight-loss and improvements in metabolic health. However, this kind of elective surgery comes with some serious risks, may result in short- and long-term complications (Heymsfield and Wadden 2017), and even then, for some procedures, 30 percent of patients do not maintain their weight loss (Berg 1999; Bacon and Aphramor 2011).

So, what accounts for the persistence of the view that diet and exercise can reverse weight gain (Vartanian 2010)? Maintaining that view certainly benefits the pharmaceutical, self-help, weight-loss, and diet industries (Jutel 2017; Mundy 2001). Many obesity researchers are on the payrolls of pharmaceutical and weight-loss companies (Oliver 2006; Fauber and Gabler 2012; Brown 2015). Additionally, prominent obesity researchers have diet books and programs to sell and thus they benefit from obesity being perceived as something that is curable (Brown 2015). In addition to profit motives, though, physicians may believe that without dogma 3, people will stop caring about their health and start rapidly gaining weight. In this sense, dogma 3 aims to put the brakes on people's behavior. Fat activist Lynn McAfee discloses in an interview a conversation she had with her doctor where she asked why the failure rates of diets aren't communicated to the public. Her doctor's response was that "no one wanted to discourage people from dieting" (Shanewood 1999). But if dieting doesn't work, why recommend it?

In sum, the decisions that established these three dogmas were illegitimately made in that they were based on insufficient evidence and for reasons that are clearly not in the stakeholders' best interests – that is, these decisions were neither epistemically nor socially justified. BMI is still heavily relied upon, because it is easy to measure and quantifiable, despite the fact that it is a *poor measure of body fat and health*. The decision to call obesity a disease was made despite the expert committee's recommendation against doing so on the grounds that there was *insufficient evidence for thinking it would improve health outcomes*. And losing weight is still widely viewed as a typical effect of changing one's diet and exercise regimen *despite conflicting evidence and the stigmatizing effects it has on the stakeholders*.

3. The Dominant Conception of Obesity and Its Influence on Research

I will now offer two examples illustrating how the medical model has functioned to preserve and further entrench itself. These examples demonstrate how the medical model influences how future evidence is collected and interpreted. As a result, obesity research is failing to achieve its epistemic aim of generating accurate knowledge about obesity.

3.1. Example 1: Mokdad et al. (2004)

In Mokdad et al. (2004), researchers examined the causes of death that are attributed to a "number of largely preventable behaviors and exposures" – one of which is "poor diet and physical inactivity." The authors determine that 400,000 deaths occur as a result of this preventable behavior, and they describe these as deaths linked to obesity. The article, however, uses all three assumptions outlined in the medical model to justify this decision. Dogma 1 – the more people weigh, the unhealthier they are – supports their conflation of those who have a poor diet and are physically inactive with people who are obese, thereby automatically excluding unhealthy people of normal weight (or underweight) when they should be included and including healthy people in larger bodies when they should be excluded. Dogma 2 – an overweight or obese body is to some degree inherently unhealthy – supports their presumption that it is obesity itself (as opposed to some other variable or a host of other variables) that caused the 400,000 deaths. And dogma 3 – people who are overweight or obese are so because they don't eat properly or exercise enough – clearly justifies the authors' assumption that obesity is "due to," or caused by, poor diet and inactivity. This is a gross oversimplification of how obesity occurs (e.g., see Mann et al. 2007, Howard et al. 2006, Gardner et al. 2007); causal questions regarding obesity and ill health are not so straightforward.

To make the inferences they made in their study, the authors conflated poor diet and physical inactivity with obesity. They write: "To assess the impact of poor diet and physical inactivity on mortality, we computed annual deaths due to overweight" (Mokdad et al. 2004, 1238-39). The researchers chose to use weight as a proxy for diet and physical activity in order to mimic the methodology used in Allison et al. (1999), a study that was actually calculating the number of deaths attributed to *obesity*, not poor diet and physical inactivity. An additional complication with using the same procedure as Allison et al. (1999) is that the statistical method used was not adjusted correctly for confounding factors (i.e., sex and age).

To determine the annual deaths attributable to obesity in a particular year, epidemiologists need to determine the number of deaths in a given year, the prevalence of obesity, and the *relative risk of mortality associated with obesity* (or RRO) (Flegal et al. 2004a). Determining the estimated annual deaths attributable to obesity can be challenging primarily because of the ambiguity of what value to assign to the RRO. The relative risk of any disease can be calculated by comparing the risk of a health event in one group versus another group. In the

case of obesity, the relative risk is determined by dividing the death risk of obese individuals by the death risk of non-obese individuals. Typically, the value assigned to RRO lies somewhere between 1.0 and 2.0, and a difference of a few tenths could vastly alter the number of deaths said to be attributed to obesity (Flegal et al. 2004b). An RRO of 1.0 means the risk of death is equal between the two groups; an RRO greater than 1.0 shows an increased risk of death for the exposed group (i.e., obese people); and an RRO less than 1.0 means there is a decreased risk of death among the exposed group.

Data can be manipulated in several ways to increase the RRO value thereby making obesity appear more deadly. For example, this could happen through data trimming[36] or, as was the case with Allison et al. (1999) and Mokdad et al. (2004), it can happen when researchers do not correctly adjust their statistical methods to account for confounding factors, such as sex and age. It is estimated that 75% of all deaths among adults occur between persons aged 65 years and older, and it is estimated that 37.5% of all deaths among adults occur in persons aged 80 years and older, even though they make up less than 5% of the population (Flegal et al. 2004). Given that most deaths among adults occur in older individuals and the considerable evidence suggesting that obesity does not adversely affect mortality among older persons (e.g., see Waaler 1984; Bender et al. 1999; Heiat et al. 2001), calculating the mortality risk attributed to obesity must take into account the RRO for subgroups within the population (i.e., age subgroups but also sex subgroups) or else risk overestimating the number of deaths attributed to obesity. Allison et al. (1999) only "partially adjusted" for confounding by using an overall relative risk that was adjusted for subgroup membership rather than different relative risks within sex and age subgroups, which led to a 17% overestimation of deaths due to obesity (Flegal et al. 2004a). Employing Allison et al.'s (1999) methods in their study explains in part the "striking finding" that approximately 400,000 deaths "occur annually *due to poor diet and physical inactivity*" (Mokdad et al. 2004, 1242, emphasis added).

[36] Data trimming sometimes occurs when researchers, usually out of good faith, attempt to isolate the effects of obesity on mortality by excluding certain populations from their calculations. For example, researchers often (1) exclude deaths that happen early on in the follow-up period (i.e., shortly after the enrollment period) for the reason that these deaths were thought to be due to pre-existing illnesses, (2) control for the effects of smoking by excluding current smokers and former smokers, (3) exclude participants with other specific health conditions at baseline (e.g., participants with heart disease or cancer), and (4) exclude people who are hospitalized or in nursing homes (i.e., a large proportion of the older population) (Flegal et al. 2004a, 2004b).

Mistaking an association between poor diet and/or lack of exercise and obesity as a causal relationship has also led researchers to overlook other potential causes of mortality.[37] For example, as Mokdad et al. (2004, 1243) note, "In this study we also did not examine the effects of high blood pressure and cholesterol or lipid profile on mortality, although some of the effects of these factors are mediated through poor diet and physical inactivity." They overestimated the excess mortality rates of people with poor diet and physical inactivity by not taking into account the possibility that it was the high blood pressure or high cholesterol (and not obesity itself) that contributed to their estimates on mortality. Choices like this are common and inflate the estimated numbers of deaths thought to be attributable to obesity. Researchers are not typically called to defend this methodological choice (because it seems straightforward according to the medical model) nor are they expected to explain how this choice influences their numbers.

Other obesity researchers, such as Katherine Flegal, have argued that it is very difficult to determine the number of deaths that are attributable to obesity alone.[38] Flegal et al. (2004a) published their own numbers and found that Mokdad et al. (2004) overestimated the number of excess deaths by nearly 300,000 and that there were no excess deaths associated with overweight people (just obese people). Mokdad et al. (2004) had to publish a correction the following year (Mokdad et al. 2005). Flegal et al. (2004a) explain that this most likely happened because most scientists have attempted to calculate this number by determining the "statistical excess of deaths among people who are obese, relative to people who are nonobese, rather than on identifying obesity as the specific cause of death for an individual" (1486). Calculating this number is particularly difficult when we consider all the possible contributing factors of obesity, ill health, and mortality, as I show in the second example.

Despite its strengths, Flegal et al.'s research (2004a) received an unusual amount of criticism, and Flegal (2021) published an article which disclosed the kinds and instances of harassment and disparaging comments she received in response to this article. Many of her critics attempted to defend Mokdad et al.'s (2004) research in spite of its shortcomings. Despite

[37] I am not denying that there may be an association between poor diet and/or lack of exercise and obesity. However, my point here is to say that the relationship is far more complicated than people typically think. Assuming that people in larger bodies exhibit these kinds of behaviors is problematic given the stigmatization and discrimination that follows.

[38] When calculating deaths that are "attributable" to obesity, the number does not refer to deaths that can be said to have been *caused by obesity alone*. The statistical excess deaths attributed to obesity will include cases in which "obesity itself *may not be the only contributing factor* to this statistical excess, but rather *a marker for other factors* such as sedentary behavior or adverse body fat distribution" (Flegal et al. 2004a, 1486, emphasis added).

consistently flagging the strengths of their work compared to others, explaining why their estimates for mortality were more accurate than previously reported, and even after defending the results of their study in various subsequent publications (e.g., Flegal et al. 2013), Flegal experienced years of unrelenting and unwarranted criticisms.[39] The nature and magnitude of the attacks Flegal received for her work convinced her that scientific research on a controversial topic like obesity will not be evaluated on the quality of the research but instead on how well it corroborates the dominant narrative:

> At first, I was startled, but eventually I came to expect partisan attacks masquerading as scientific concerns. I had expected some modest interest in our findings, pursued through normal channels of scientific discussion. I had not expected an aggressive campaign that included insults, errors, misinformation, behind-the-scenes gossip and maneuvers, social media posts and even complaints to my employer…It seemed that some felt that our work should be judged not on its *merits* but rather on whether its findings *supported the goals and objectives of the interlocutors*. I saw first-hand the antagonism that can be provoked by inconvenient scientific findings…Development of public health policy and clinical recommendations is complex and needs to be *evidence-based* rather than *belief-based*. This can be challenging when a hot-button topic is involved. Scientific findings should be evaluated on their *merits*, not on the basis of whether *they fit a desired narrative*. (Flegal 2021, 78, emphasis added)

Again, the question we should ask is what foundational assumptions are these criticisms of Flegal's work relying on? Since one of the controversial inferences derived from Flegal's results is that being overweight is healthier than being "normal weight," it is likely that her critics endorse dogma 1 (i.e., that the more one weighs, the unhealthier they are). It may also be the case that well-meaning critics are assuming that obesity is inherently bad (dogma 2) and therefore believe that any evidence that is not incriminating could be "detrimental to public health goals" (Ibid., 76).

While the goal of improving public health is laudable, we must first ask whether Flegal's evidence is in fact detrimental to this goal and *also* whether it is detrimental to the epistemic goals of obesity research. It is not clear why Flegal's research – which was reviewed extensively by scientists at the CDC and NCI as well as journal reviewers and editors, is still cited frequently, and has been confirmed by other research – should be viewed as something that is

[39] See Flegal (2021) for a list of all published responses to her critics.

detrimental to the epistemic aims of research. In fact, the opposite is probably true. Rather, it is Flegal's critics who want to "stomp out" (Raeburn 2007)[40] any ideas that conflict with the dominant narrative that obstruct the epistemic aims of research. Provided that Flegal's research is beneficial to obesity research – i.e., by challenging strongly held biased beliefs about the health statuses of "overweight" and "normal weight" people – it is also very unlikely that her research is detrimental to the social aim of improving public health.

3.2. Example 2: Ades and Savage (2010)

The "obesity paradox" is a concept that was coined by Luis Gruberg and colleagues in 2002 to describe the circumstance in which, contrary to their hypothesis, thinner patients' risks of dying were roughly double that of overweight or obese patients within a year after undergoing angioplasty (Lavie 2014). Since then, the obesity paradox, or the phenomenon suggesting that there is an inverse relationship between body fat and risk of death, has been observed across various diseases (e.g., see Hainer and Aldhoon-Hainerová 2013; Lavie et al. 2003; Kalantar-Zadeh and Kopple 2006). In the case of type II diabetes, for instance, it has been shown that type II diabetics who are overweight and even obese outlive their normal weight counterparts (Han and Boyko 2018).

The obesity paradox has raised controversy among obesity researchers because it calls into question the correlation between obesity and mortality and suggests that obesity may actually be *protective* against death in some cases. In response, critics have tried to debunk the obesity paradox as a myth.

Consider the work of Ades and Savage (2010). Three central problems arise in this article. First, the authors make it clear that they are on a mission to debunk the obesity paradox theory. In other words, they assume that being overweight or obese is itself unhealthy (i.e., dogma 2), which is precisely the question up for discussion in the obesity paradox debate. Rigorously evaluating a claim (e.g., the obesity paradox) is not a problem, but their fear that obesity paradox research may discourage people from trying to lose or maintain body mass

[40] One of Flegal's harshest critics, Walter Willett, was quoted saying this in response to research suggesting that "it's better to be overweight" (Raeburn 2007). He said that about every 10 years this kind of research makes a comeback and "we have to stomp it out" (Ibid.).

This is of course an extreme example of how resistant some researchers can be to evidence that challenges the medical model. I am not at all suggesting that all, or even most, obesity researchers are this resistant. However, it is interesting how "surprisingly effective" the "small number of vocal critics…[were] in raising considerable doubt" about Flegal and her colleagues' work (Flegal 2021, 78).

influenced the way they collect and interpret data. Second, to defend their hypothesis that the obesity paradox would not exist if studies had accounted for confounding variables, the authors rely on a study (McAuley et al. 2010) whose sample group is far too homogeneous to generalize to the U.S. population. And lastly, the authors say that had studies suggesting the existence of the obesity paradox adjusted for other confounding factors (e.g., excessive alcohol use, illicit drug use, or AIDS), the effect would have been "blunted," though they fail to consider how adjusting for other confounding variables (e.g., weight stigma or yo-yo dieting) could provide more evidence *for* the existence of the obesity paradox.

In the introduction of their paper, Ades and Savage explain how the obesity paradox "seems relatively easy to refute or explain given that weight loss and physical frailty are often a final common pathway to mortality" (2010, 112), and they later explain how they've been motivated to write this piece because the theory of an obesity paradox sends a "dangerous message" (113). This perspective is imbued with normative beliefs about obesity and assumes the nonexistence of the very phenomenon that is up for debate. To dismiss the existence of the obesity paradox, the authors say the effect is "blunted" when adjusting for cardiorespiratory fitness.

Ades and Savage (2010) cite McAuley et al. (2010) to defend this point. However, one of self-reported limitations of McAuley et al. (2010) is what has been called the "veteran effect." This means that the sample group, consisting entirely of veterans, doesn't adequately represent the population because these individuals (1) had to meet particular height and weight requirements, (2) could not have or develop any health complications (e.g., asthma, heart or vascular defects), (3) were required to maintain a particular level of fitness throughout their enlistment, and (4) were all male (McAuley et al. 2010). Additionally, the sample group consisted entirely of middle-aged men.

Using this kind of sample group undermines researchers' ability to generalize the results, which is precisely what Ades and Savage (2010) try to use this data for. If the sample had included females, people of various sizes, levels of fitness, and age, and people who have various background medical conditions (i.e., if the sample actually represented the U.S. population), the estimated risk of obesity would be lower. Instead, the estimated risk of obesity in this study is only an appropriate estimate for individuals who have a similar history to male veterans. In their attempts to show that people in larger bodies are unhealthier than their normal-weight

counterparts, Ades and Savage resort to using data that is not representative of the population without mentioning how this affects the strength of their argument.

Additionally, despite the fact that McAuley et al.'s (2010, 120) study shows that "both high fitness and higher BMI independently reduced mortality risk," Ades and Savage (2010) argue that because the effect is less prominent once the data is adjusted for cardiovascular fitness, this suggests that had the authors also adjusted for chronic lung disease, excessive alcohol intake, illicit drug use, AIDS, or other issues, "the obesity paradox may have further dissipated or disappeared" (114). In other words, it is assumed that if people of normal weight have higher mortality rates, then it must be because of some underlying and undefined medical condition (i.e., given dogmas 1 and 2).

Even though it may be the case that these confounding factors reduce the mortality rate of normal-weight people, there are confounding factors that could be adjusted to reduce the mortality rate among people in larger bodies as well, but these types of variables do not receive much attention. For example, epidemiological studies on the mortality risk associated with overweight and obesity often fail to take into consideration confounding factors such as family history of various illnesses, personal history of abuse, or the presence of mental illnesses (Gard and Wright 2005; Lavie 2014; Cortese et al. 2016; Gay 2017; Laymon 2018; Khazan 2015). Evidence shows that weight stigma – and stress generally (Tomiyama 2014; Tomiyama and Mann 2013) – as well as lack of healthcare coverage (Lavie 2014) are independent risk factors for various negative health outcomes regardless of body size (Vadiveloo and Mattei 2017). Additionally, multiple attempts to lose weight, or "yo-yo dieting," may increase one's risk for cardiovascular disease, and impair one's self-confidence and emotional well-being (Brownell et al. 1986; Brownell and Rodin 1994). In other words, whether and what confounding variables are accounted for appears dependent on whether they support the medical model or not.

The selective attention of obesity researchers to certain confounding factors and the overly critical reactions to Flegal's research illustrate how the social repercussions of research that challenges the medical model has influenced obesity research design in ways that support the medical model. Obesity researchers are worried that public health will deteriorate if such research gets uptake and cause public confusion which would thus undermine the confidence people have in science (Flegal 2021; Ades and Savage 2010). It is assumed that if obesity is more harmful than what is conveyed in, for example, research supporting the obesity paradox,

the risk associated with this error would outweigh the risks generated from overly stringent public health and medical recommendations (Douglas 2000). These kinds of risk assessments understand the possible detrimental effects associated with obesity to exceed those related to weight stigma, weight-loss medications, dieting, etc. As a result, many believe evidence suggesting that obesity may not be as unhealthy as we had once thought is irresponsible and possibly even immoral given the dominant conception of obesity.

Obesity researchers are inattentive to how non-epistemic values influence how they weigh certain epistemic values (e.g., consistency or simplicity) over others (e.g., accuracy or breadth) and how they even understand "accuracy." This is particularly concerning given how these non-epistemic values make way for research designs that further entrench the assumptions of the medical model. This approach to obesity research impedes epistemic efforts to better understand the nature of obesity and is not democratically informed by the values of stakeholders.

4. Conclusion

I have argued that the medical model was illegitimately established and maintained in ways that conflict with the aims of obesity research. By relying on illegitimately established medical model dogmas to justify methodological choices, obesity researchers are impeding their epistemic endeavors to generate accurate beliefs about the biological processes happening in the body, specifically as it relates to the accumulation of adipose tissue. Additionally, given other evidence – for example, about how difficult it is for people to intentionally lose weight and the harms of weight stigma – these methodological choices are also not helping researchers achieve their social aim of improving health. The problem is not that obesity research relies on values; the problem is that it sometimes relies on the wrong kinds of values – values that are mistakenly said to be in the interest of health.

Given the social aim of improving health, obesity researchers working to achieve their epistemic aims to understand the complexities of fatness ought to incorporate social, ethical, and political values that better promote this democratically endorsed social aim (Intemann 2015). To do so, they need to take into account and weigh more heavily the epistemic and non-epistemic values of stakeholders and restrict the influences of weight-loss and pharmaceutical industries. Given the great economic and political power of the weight-loss and pharmaceutical industries, their interests should count less than the interests of those who are less well off (Brown 2020).

The resulting research would explicitly acknowledge its value judgments about which types of models, methodological approaches, conceptual frameworks, or strategies for dealing with uncertainties that best promote stakeholders' interests. In the last chapter, I will provide a more detailed explanation of the way research regarding people in larger bodies should be conducted.

A central aim of this chapter was to demonstrate why the concern for health objection to the fat acceptance movement is not nearly as sturdy as people presume. Not only is the obesity research that has informed the "obesity epidemic" framework less reliable or straightforward than many presume, but it is also not really in the interest of improving health. Given that the concern for health objection is based on research that is not actually in the interest of promoting the health of people in larger bodies (despite researchers' self-proclaimed aims), how can anyone confidently say that the concern for health objection is coming from a place of genuine concern about health?

In the following chapter, I will build on the ideas presented in this chapter that are based in feminist epistemology of knowledge. I will further elaborate on the harms that come from taking the dominant narrative (i.e., the medical model) as a more reliable source of information than first person testimonies of people in larger bodies. Where this chapter explored how anti-fat assumptions influences what models of knowledge we use to justify these assumptions, in the following chapter, I will explore how anti-fat assumptions influence who is considered a knower, whose claims are accepted within the epistemic community, and how this *systematically* influences the distribution of knowledge and ignorance and perpetuates fat oppression (Anderson 2020). Thus, not only does reliance on the medical model negatively affect the epistemic aims of research, but it perpetuates systemic epistemic harm.

Chapter 3: Understanding the Medical Model as an Ideology Sustaining Systemic Epistemic Injustice

In the previous chapter I demonstrated how the medical model of fatness has illegitimately influenced obesity research, public health recommendations, and treatments in ways that are more harmful than helpful. Furthermore, the overly narrow and medicalized lens through which all bodies are evaluated makes it difficult for any other alternative perspectives that do not coincide with the medical model to get recognized or taken seriously – this includes personal testimonies of people whose bodies are being criticized. Not only do obesity researchers fail to consider alternative explanations for data they observe, fat activists' experiences and perspectives that do not corroborate the medical model are mostly dismissed by researchers, physicians and the general public. Rather than questioning the medical model and the anti-fat biases and assumptions that pervade it, the fat-positive testimonies of people in larger bodies get questioned.

In this chapter I intend to further motivate the idea that the medical model is the underlying problem perpetuating fat oppression today. I motivate this point by calling the medical model a deeply entrenched *ideology*. I use Sally Haslanger's (2017) conception of ideology, which she describes as "a culture gone wrong." A culture is "a network of social meanings, tools, scripts, schemas, heuristics, principles, and the like, which we draw on in action, and which gives shape to our practices" (Ibid., 155). The culture goes wrong (and becomes an ideology) because it organizes us in unjust ways and skews our conception of what is valuable (Haslanger 2017). But value is "appreciated through" and "created through" entrenched *social practices*, so critiquing the ideology itself is unhelpful (Ibid., 163). Thus, I use ideology to argue that epistemic justice cannot be achieved by critiquing unjust prejudices, biases, or beliefs that contribute to injustice nor can it be achieved by critiquing the ideology itself. We need to critique the coordination system that structures our social practices in unjust ways and that does not engage in "epistemically responsible practices of reflection and internal critique" (Ibid., 164; Haslanger 2019)

To make this argument, I will, in §1, demonstrate some ways in which people in larger bodies experience epistemic injustice – that is, the ways in which they are wronged in their capacity as knowers (Fricker 2007). Then, in §2, I will argue that many of the cases of epistemic injustice that people in larger bodies experience occurs as a result of a system of oppression that

is self-regulating and self-sustaining and is enacted by an ideology – i.e., the medical model – that functions in the background (Haslanger 2023). I will ultimately argue that because individuals (both the dominating *and* subordinated group) are often unknowingly being shaped by the ideology, resolving fat oppression will require more than just calling upon agents to practice certain epistemic virtues – it will require a cultural revolution (Fricker 2007). In §3, I will explain why paying more attention to certain aspects of epistemic injustice that has at times been neglected play important roles in sustaining the system of injustice that produces epistemic harms. And finally, in §4, I will address a potential objection to my argument that people in larger bodies experience a systemic epistemic injustice. Some might think that it would be more appropriate to characterize the epistemic injustices described by fat activists as simply singular occurrences of epistemic injustice as opposed to a systemic epistemic injustice. In response to these concerns, I argue that fat oppression has become so immersed in society's culture that people in larger bodies have internalized their oppression, and for this reason we should not ignore fat-negative testimonies but rather, be attentive to the way in which fat oppression influences these perspectives, which can be used to further surveillance, control, and moralize fat bodies (Meleo-Erwin 2010).

1. An Overview of Epistemic Injustice

In this section I give a brief overview of the terms "testimonial injustice" and "hermeneutical injustice" and describe how they manifest in the context of fat oppression. In the next section, I will frame these concepts in the context of ideological oppression to offer a more comprehensive explanation as to how these injustices are being perpetuated.

1.1. Testimonial Injustice

Testimonial injustice occurs when a speaker suffers a credibility deficit as a result of *negative identity prejudice* (Fricker 2007). Identity prejudice is a preconceived opinion about a person based on their social identity. As such, an identity prejudice can be *positive* – where baseless assumptions/biases about a social identity lead to one being perceived as someone who possesses positive characteristics, e.g., trustworthy, intelligent, infallible – or it can be *negative* – where baseless assumptions/biases about a social identity lead to one being perceived as someone who possesses negative characteristics, e.g., untrustworthy, lazy, unreliable, unintelligent. A negative identity prejudice is what is often what is thought to cause testimonial

injustice to take place because it is the reason why the speaker is not taken to be a credible knower. Moreover, what allows the hearer to effectively discredit or silence the speaker is the *social power* she has to control the interaction (e.g., the direction it takes and how the speaker is perceived by others). While testimonial injustice occurs at the interpersonal level, the power with which the hearer can effectively discredit or silence the speaker, arises from the collective social imaginary.[41] The social imaginary is "[t]he repository of images and scripts that become collectively shared… [and] constitutes the representational background against which people tend to share their thoughts and listen to each other in a culture" (Medina 2013, 67). In short, the social imaginary can be understood as the dominant narrative against which people in a society make sense of things.[42] It is from the collectively shared ideas, images, assumptions, beliefs, and values that make up the social imaginary that harmful and unjust biases, stereotypes, and ideologies develop.

For example, people in larger bodies who are fitness instructors or dietitians often experience credibility deficit simply as a result of negative identity prejudice (Green 2022). In other words, due to the social imaginary around fatness and health – i.e., that larger bodies are not healthy and develop as a result of eating a poor diet and not exercising – people don't think that people in larger bodies could be good fitness instructors or dietitians. As one larger-bodied fitness instructor puts it, "Because of the size of my body, I am not found as credible and I am treated as some kind of comedy act and overlooked for opportunities" (Ibid.). Non-fat fitness instructors and clients are not as likely to take larger bodied fitness instructors seriously or as being able to perform well at their job. Regardless of their qualifications or the years of experience they have, the negative identity prejudice overpowers any evidence for thinking that a larger-bodied individual could be a good fitness instructor.

[41] Throughout the remainder of the dissertation, when I refer to the social imaginary, I am referring to the *dominant* social imaginary, unless it is described otherwise. In other words, it is the social imaginary that the dominant group uses to make sense of things. Marginalized identities, due to their unique experiences as Other, have developed other resources and means for making sense of their own experiences. As I will explain later in the chapter, people belonging to marginalized groups often experience epistemic injustice because their audience (that relies on the dominant social imaginary) is incompetent and therefore, they can't transfer their knowledge to their audience.

[42] For the purpose of this chapter, I use the terms social imaginary (i.e, the *dominant* social imaginary) and dominant narrative interchangeably. They both get at the idea that there is a collection of images, meanings, ideas, assumptions that were cultivated by and for people belonging to dominant groups to coordinate, manage, and communicate within society. The social imaginary/dominant narrative is also used by people in marginalized groups to be able to also get by in a society that was not fashioned for them.

This is just one example of how biases, stereotypes, and ideologies that derive from the social imaginary influence material realities. The effects of credibility deficit can be seen in health care (Friedman, Rice, and Rinaldi 2020; Wann 1998; Brown 2015), in education (Cameron and Russell 2016), on the job market (Vanhove and Gordon 2014), and in the workplace (Roehling 1999). For example, empirical research shows that people in larger bodies are less likely to get hired for a job (Bellizzi and Hasty 1998; Giel et al. 2010; Vanhove and Gordon 2014), more likely to get passed up for promotions (Roehling 1999), and do not get paid as much (Ibid.). People in larger bodies are perceived as being "significantly less neat, productive, ambitious, disciplined, and determined" because of their weight and despite their qualifications or their success in the position (Puhl 2012, 789). In other words, through the lens of anti-fat bias, a larger-bodied applicant's qualifications and work ethic are not taken to be reliable indicators of their ability to perform well at the job.[43] The material consequences of epistemic injustice illustrate that "the self-sustaining system is not just in the head: it includes both culture and material conditions" (Haslanger 2021, 751).

1.2. Hermeneutical Injustice and the Dominant Social Imaginary

The testimonial injustice that people in larger bodies experience is inextricably linked to *hermeneutical injustice*. A hermeneutical injustice occurs when "someone has a significant area of their social experience obscured from understanding owing to prejudicial flaws in shared resources for social interpretation" (Fricker 2007, 147). It is no coincidence that those who often have a difficult time understanding their experiences – due to the limited collective hermeneutical resources available for one's disposal – are members of marginalized social groups. This is because the social imaginary, which informs the (dominant group's) collective hermeneutical resources, is shaped by systems of oppression. The collective hermeneutical resources that everyone relies on to varying degrees were constructed by and for those in more privileged social groups – they benefit those with social power at the expense of the powerless.[44]

[43] I am not claiming that these are all due primarily or only to epistemic injustice, but that they are likely linked to some form of epistemic injustice. For example, despite one's qualifications for a particular job or a promotion, a person in a larger body may experience a kind of testimonial injustice during the interview.

[44] For example, prejudicial stereotypes about Black/Latino women as welfare mothers come about as a result of the collective hermeneutical resources used by everyone to varying degrees that reinforce racism.

The medical model is what I believe influences the social imaginary around fatness/health that perpetuates fat oppression. What is particularly troublesome about fat oppression is that people think the medical model is justified and therefore, the collective hermeneutical resources are not called into question as they are believed to be working in a way to promote health. As fat activist Marilyn Wann explains:

> The "health" argument is a big old smokescreen for our old friend: fat hatred. When people realize they can't get away with expressing their prejudice against fat outright, they use *the health argument* instead, but the emotion behind their words is still hatred…Fat hatred and thin worship are so ingrained and constant in our culture that most people are not even aware of these beliefs as choices. They seem like *givens*, fixed parts of the landscape. Fat prejudice is like a *blind spot. Sometimes you can't see it, even when you're looking directly at it*. (Wann 1998, 33-34, emphasis added)

Testimonies like this are common among fat activists and suggest that our society's staunch support of the medical model has perpetuated a *hermeneutical injustice*. In other words, the medical model has created a gap – or in Wann's words, a *blind spot* – "in our shared tools of social interpretation" (Fricker 2007, 6). In this way, the medical model not only perpetuates injustice but also functions in a way that hides the fact that it's perpetuating injustice.

However, hermeneutical injustices aren't always discernible. It is particularly difficult for those who are not harmed by or perhaps even benefit from the gap to recognize it, but it is also difficult for many (if not most) oppressed individuals who have internalized their oppression.[45] Those who are still able to retain some degree of self-definition in the face of constant harassment and stereotypes, will come to acquire "double consciousness" (DuBois 2016/1903). Various scholars (DuBois2016/1903; Collins 1990; Lugones 2003; Medina 2013) have claimed that double-consciousness has the potential to make one epistemically advantaged. This is because double consciousness offers people the ability to shift between the two incompatible perspectives – i.e., the perspective of the dominant narrative and one's own perspective – and thus, have the opportunity to compare and contrast these perspectives. This can provide oppressed individuals with a "special source of critical power and lucidity" that is often invisible to privileged people (Medina 2013, 194). In fact, it has been argued that because of the insight people of color have about their experiences, the mechanisms of oppression, and the way in

[45] Internalized oppression has also been called "infiltrated consciousness" (Nelson 2001) and "psychological oppression" (Bartky 1990; Cudd 2006).

which these mechanisms are produced, that people of color have a better understanding of white people than white people do (Medina 2013; Johnson 1912/1995; Wylie 2003).[46]

After having endured years of pain, shame, and yo-yo dieting, fat activists have developed an ability to recognize problematic assumptions in the medical model and renounce diet culture. By reflecting on their experiences, they have recognized the contradictions between the obesity epidemic's campaign for health and the pain and suffering that it fuels. These experiences may sometimes allow people in larger bodies to recognize the limitations and flaws of this dominant narrative. However, if the power of the dominant culture becomes too overwhelming, maintaining double consciousness (and the epistemic advantages that come with it) can be difficult:

> I have tended to think it unhealthy for oppressed peoples to obsess over the oppressors' perception of their subjectivity. One becomes both fascinated by it and overwhelmed by its power. Understanding the extent to which we have internalized it paralyzes one.... there is a deep fear of losing this…source of a resistant subjectivity. This fear is analogous in my experience to the terror that seizes acute chronic pain sufferers: the fear that the pain may take over your whole consciousness and leave nothing in you except consciousness of pain, all other subjectivity erased. One fears that *one may become what one is in the racist perceiver's eyes, and nothing else, all other subjectivity erased*. (Lugones 2003, 124-127)

It can be difficult to reconcile two very different perspectives, especially when the dominant perspective is so powerful. This is why, as a result of cognitive dissonance, oftentimes members of oppressed groups can only access one perspective at a time (Collins 1990; Medina 2013).

For instance, while fat activists have come to recognize that the problem with the "obesity epidemic" is not that their bodies are unhealthy but rather, that this framework is oppressive, they still struggle with self-acceptance. The prevalence of anti-fatness and diet culture makes it incredibly difficult for a person in a larger body to hold a positive (or at least neutral) perspective of oneself while also recognizing that one is being perceived in a negative light by society. For instance, consider the extent to which the phenomenon called "fatcalling" has been a persistent feature of Gordon's (2020) life – to the point that she has been *conditioned* to think about how her body will be perceived by others every time she leaves her home:

[46] Medina (2013) and Wylie (2003) clarify, however, that we should not assume that all marginalized identities are epistemically advantaged nor that all privileged identities are epistemically disadvantaged.

> Strangers' interjections about my body, my food, my clothing, and my character are a daily feature of my life as a very fat person…. Like street harassment facing thinner women, fatcalling is also rooted in a deep sense of entitlement to others' bodies…. Fatcalling shapes that unpredictable world in which fat people live. Will a passerby smile warmly, or spit an epithet at my broad, soft body? Will a doctor examine me, offer up treatment options, or will I be ejected from her office? Fatcalling offers only intermittent reinforcement—the uncertainty of abuse, replicated on an all-consuming, societal scale. As a fat person, I have developed a *Pavlovian response* to situations that may invite fat hate. Left wondering whether or not it would materialize, I have learned to *anticipate it everywhere*, because it could show up *anywhere*. Anticipating and avoiding fatcalling is *baked into every aspect of my life* as a fat person. (Gordon 94, emphasis added)

Given the extent to which anti-fatness affects the lives of people in larger bodies, it is not shocking that so many of them want to lose weight. Even fat activists who exhibit much pride in their bodies are affected by the dominant narrative of fatness because they can't help but view their bodies through the dominant lens:

> I can honestly say that *I love my body* and am *happy with being fat.* But occasionally, when I look in the mirror and I see this body that is so different from my friends', so different from what I'm told it should be, I just want to hide away and not deal with it anymore. (Lamm 2019)

Despite generally being happy with their bodies as they are, fat activists cannot fully escape cultural body norms and pressures. Cultural attitudes toward fat bodies and the thin ideal are what often prompt people of all sizes to want to lose (or maintain their) weight.[47]

Despite the overwhelming power and prevalence of anti-fat sentiments, fat activists have noticed the blindspot (i.e., fat prejudice) and consequently, have argued that the fat acceptance movement is not about health, it's about justice – it's about dismantling the fat prejudice that hides behind the guise of health. However, these testimonies don't get much uptake because of the limited hermeneutical resources around fatness that are grounded in an overly pathologized view of fatness. People in larger bodies are largely excluded from participating in knowledge

[47] Although most people who attempt weight-loss are often prompted to do so because of cultural attitudes and norms, it's important to recognize that this is not *always* the case. Some people may try to lose weight for the purpose of being able to carry out some unrelated goal or desire, as I will explain in more detail in the following chapter. Other people may desire to lose weight to an unhealthy degree, as is the case with eating disorders. However, the cause of eating disorders is sometimes not related to cultural body norms at all but relates instead to triggering traumatic events ("Eating Disorders, Trauma, and PTSD" 2017). Eating disorders are also often co-occurring with various psychiatric disorders, so it is important to recognize the complexity behind a person's desire to lose weight or to have complete control of diet and exercise (Ibid.).

production around their own embodiments and this is because of limited, anti-fat hermeneutical resources. Given that the epistemic resources available for generating knowledge about fatness is largely influenced by the medical model, it is difficult to develop a concept of fat as a political identity that is neutral with respect to well-being. What overpowers the messages of fat activists is the medical model ideology that is believed to be used in the interest of promoting people's health.

The concern for health argument is what makes fat oppression so unique – anti-fatness is not just prevalent (like racism, sexism, or homophobia) but it is overt and justified. For instance, fat shaming is sometimes thought to be justified (Casey 2019)[48] because some believe that it will reduce the prevalence of fatness (Callahan 2013). Even well-meaning messages about health can potentially stigmatize and gaslight people in larger bodies.

> Gaslighting shows up in diet culture a lot. There are real cultural problems—like sexism, body shame, fatphobia, and myriad injustices many of us are dealing with all of the time—and yet we are told over and over again by mainstream narratives that these problems reside within us...we are told—and we believe—that the problem is that we aren't trying hard enough (Tovar 2018).

Gaslighting, or the event in which people are manipulated into distrusting their own experiences, is a common occurrence in the lives of people in larger bodies, particularly now that society is attempting to cover up anti-fat messaging with anti-poor health messaging. Take, for instance, First Lady Michelle Obama's Let's Move! Campaign. Despite the intention to improve health and reduce health disparities, the health initiative actually perpetuated the insidious nature of the medical model:

> The war on obesity reached its *zenith* under First Lady Michelle Obama, whose Let's Move! Campaign… frequently referred to the program as 'America's move to raise a *healthier* generation of kids' through advocating that children *lose weight.* This subtle but definite shift in language continued to prop up the thinking that conflated *weight with health*. Thin people "looked healthy"; fat people were met with concern for our health. Weight loss became not about "slimming down" but about "getting healthy." *No fat person, it seemed, could be as healthy as any thin person*, regardless of our mental health, reproductive health, blood pressure, blood sugar, T-cell count, or any other measure of a vast, multifaceted, and still

[48] For example, Bill Maher, who hosts HBO television show *Real Time with Bill Mayer*, closed one episode with a comment on fat shaming: "Fat shaming doesn't need to end, it needs to make a comeback. Some amount of shame is good. We shamed people out of smoking and into wearing seat belts. We shamed them out of littering and most of them out of racism. Shame is the first step in reform" (Paul Casey [dir.], Season 17, Episode 26, Aired September 6, 2019).

> underexplored bodily system's measure of health…. This was a campaign against "childhood obesity…It was a campaign *against a body type*—and more than that, a child's body type…. Michelle Obama's Let's Move! Campaign…opened the doors to an even more vicious front in its new war on childhood obesity. (Gordon 2020, 37, emphasis added)

The initiative, whose interest was to promote health, did so in a way that still demonized fat bodies. When anti-fat messages are constantly being expressed in the media, schools, doctor's offices, and homes, and are packaged in a way that sounds like a concern for health, people in larger bodies may seriously question whether what they experience is an injustice. What these messages often do is reinforce the internalized oppression people in larger bodies already experience.

Again, we can see how the medical model – which understands fatness as antithetical to health and as something that a person can treat through individual behaviors – is often contributing to the epistemic injustice that people in larger bodies experience today. Because of the way in which fatness is largely understood, it is not simply a problem for medical providers nor is it simply something that the media sensationalizes in a way that targets the vulnerabilities of young girls and women. Rather, fatness is something that everyone feels they have a right to comment on because it is understood to be a public health crisis, a national security threat, and an economic burden. This is why cases of epistemic injustice are not one-off instances nor are they localized to a specific context (e.g., in medical research or the health industry). People in larger bodies do not experience *incidental* testimonial injustice. Since anti-fat assumptions, biases, and stereotypes follow people in larger bodies through every aspect of their lives, the testimonial injustice is *systematic* (Fricker 2007). The injustice experienced is persistent because the stereotypical images, biases, and assumptions that "operate beneath the radar of our ordinary doxastic self-scrutiny" are a part of the social imaginary (40).

In the following section, I argue that a more appropriate explanation for how most of the epistemic injustice that people in larger bodies experience today is through understanding the medical model as a deeply ingrained ideology that is perpetuating a systemic injustice (i.e., fat oppression).

2. Reconceptualizing Epistemic Injustice in the Context of Ideological Oppression

While it is certainly true that agents silence speakers (Fricker 2007), distort testimonies (Falbo 2022), and coerce speakers to smother their testimony (Dotson 2011), describing the epistemic injustice people in larger bodies experience as mere *instances* performed by *agents* overlooks the ways in which injustice is often sustained unknowingly and how the morally relevant features are often obscured. The problem isn't that some or even most individuals hold problematic values that inflict these epistemic harms, the problem is that our society is organized around, and our practices informed by, problematic values that appear legitimate (Haslanger 2017). To clarify the way I understand the epistemic injustice that people in larger bodies are subject to, I will contextualize epistemic injustice in the context of *ideological oppression*.

Ideological oppression is a kind of oppression that is perpetuated by a *culture* that "stabilize[s] or perpetuate[s] unjust power and domination, and does so through some form of masking or illusion" (Ibid., 150). In comparison, epistemic injustice is often thought to be caused by systematic prejudice (in cases of testimonial injustice), or systematic hermeneutical marginalization (in cases of hermeneutical injustice), or both in varying ratios, depending on the view.[49] To explain how epistemic injustices are produced, however, epistemologists employ the term social imaginary, which is often used to refer to a set of collectively shared ideas, images, assumptions, beliefs, and values that contributes to epistemic injustice (by, for example, giving rise to identity prejudices). Formulated in this way, the definition of social imaginary sounds relatively similar to that of culture, but there are important features of the phenomenon I'm describing that are best captured by *culture*.

2.1. Culture influences our social practices, not our individual psychological proclivities

The concept "imaginary" has roots in psychoanalytic theory (e.g., see the works of Cornelius Castoriadis, Jacques Lacan, Luce Irigaray),[50] though it has also been employed by existentialists (e.g., Merleau-Ponty 1945; Sartre 1940/2004) and more fittingly, feminist philosophers, social/political philosophers, and feminist metaphysicians (e.g., see Butler 1990; Gatens 1996). In the context of psychoanalytic literature, the imaginary has been used in a way

[49] For example, Medina (2013) argues that hermeneutical and testimonial injustices have a "deeper connection [than Fricker leads on] in which these two types of injustices become intertwined, feeding into each other and deepening the effects of each other" (96).

[50] While the social imaginary or social imagination has roots in psychoanalytic theory, it is argued that these theorists were influenced by philosophical accounts put forth by Descartes, Hume, and Spinoza. For example, Moira Gatens (1996) makes it very clear that her use of the term is influenced by the work of Spinoza.

that places much emphasis on the psychological mechanisms that shape our experiences and respond to our social environment, but this conceptualizes the imaginary in overly individualistic terms (Haslanger 2019). Despite the ties to psychoanalytic theory, the imaginary can be helpful in explaining how people within a society continue to unintentionally endorse and perpetuate oppressive meanings, tools, scripts, principles, assumptions, etc. even when formal and legal barriers to full social and political representation of marginalized identities are removed (Gatens 1996; Haslanger 2017). For example, in the context of sexism, Gatens says:

> The effects of women's historical exclusion from citizenship *do not vanish* once women are enfranchised. There is a multiplicity of *embodied habits, customs and laws* which continue to bear the scars of that exclusion. The removal of formal bars to women's sociopolitical representation does not amount to full participation in legal and political institutions, since those institutions have histories that *continue to function in ways that deplete women's powers of action*…there are some…who *unreflectively endorse and perpetuate a sexual imaginary* in which women embody the paradox of being considered as *both* free and rational members of a democratic political body *and* beings under the 'natural' authority of men. (141, original and added emphasis)

The imaginary is not simply constructed through one's personal psychological experience. Rather, the *social* imaginaries that feminist and social/political philosophers are concerned with are those (that are often unconscious) that stem from specific cultures that are used to make sense of social bodies, their value, and their role in society (Gatens 1996; see also Haslanger 2019). As Haslanger (2017) puts it, "Thought, perception, emotion, and other psychological states depend on a public 'field of preexisting meanings'... [which] shapes and conditions our experience and agency, and provides a kind of palette of psychological content" (155). The "field of preexisting meanings" that shape our psychological content are largely influenced by culture. Thus, to make clear that the kind of "social imaginary" that is operating in my theory of epistemic injustice is just as much social (if not more so) as it is psychological, I will instead use the term *culture*.

Why does this matter? Because while culture does influence cognition, it also influences agency and structures one's identity, so critiquing the individual for participating in a case of epistemic injustice falls flat because their participation appears called for (Haslanger 2017). The problem with a doctor who, for instance, assigns a patient in a larger body with less credibility than she should due to anti-fat prejudice is not that they are ignorant per se, but because our society is organized around problematic values. The doctor is relying on a lot of information she has learned throughout her career – what she was taught in medical school, the behaviors and

choices of other doctors (e.g., choices pertaining to prescriptions, diagnosis, how to evaluate various health markers), the knowledge exchanged in their day-to-day social interactions, the drug information obtained through pharmaceutical representatives, etc. – which both initially informed and then later entrenched their thoughts and patterns of behavior. So, if we're trying to make progress toward justice, critiquing the doctor's behavior can only do so much because she's acting on ideas that are prevalent within the institution of medicine and society at large – *she is acting on the ideology that is the medical model*. If we ignore the ways in which the doctor's cognition is "socially shaped and filtered," then we run the risk of allowing the ideology that is shaping and filtering her views to go "unnoticed and unimpeded" (Haslanger 2019, 5).

2.2. Culture shapes our "strategies of action" and identities

Though culture does shape our values to some extent, more importantly, it shapes our actions and identities by "shaping a repertoire or 'tool kit' of habits, skills, and systems from which people construct [diverse] 'strategies of action'" (Swindler 1986, 273). Strategies of action "are the larger ways of trying to organize a life…within which particular choices make sense, and for which particular, culturally shaped skills and habits…are useful" (Ibid., 276, fn 9). If culture simply influenced our action by shaping our values, then lower-class and middle-class families who are shown to have similar values (e.g., education, stable marriages, steady jobs) should have similar patterns of behavior (Swindler 1986). However, the reality is that culture organizes these families of different socioeconomic status in different ways. Culture does not offer all agents with the same tools to be employed in the same ways nor does it guide action in the same direction. For instance, children of lower-class background may not take steps to pursue a "middle-class path to success" not because they didn't want that for themselves but rather, because it can be particularly challenging for those to pursue this course of action if "the accepted skills, style, and informal know-how are unfamiliar" (Ibid., 275). As a result, a child born into a lower-class family may develop and hone certain cultural tools and skills that are more familiar to them, which leads them to pursue a different course of action. Culture "provides resources for agency. One needs to gain the skills to navigate (both interpret and employ) the social meanings that partly constitute dominant practices" (154). We all eventually and unintentionally get shaped by the system we participate in by becoming fluent in the practices and internalizing the relevant norms, which eventually fashion our identities (Haslanger 2017).

A culture that values thinness will influence an individual's strategies for action in varying ways, depending on her situatedness. The actions of a middle-class white woman, for instance, will be constrained and shaped by things like body and beauty norms and the advice or actions of others (Swidler 1986). Even if she very much disagrees with society placing so much value on thinness, it may nevertheless influence her actions and shape her identity. Being raised in an environment where norms, advice, and actions that encourage and further entrench the value of thinness are prevalent, a middle-class white woman will become fluent in the social practices within the system. Because she still cares about how she's perceived in the world despite thinking that it's unfair for her to have to live up to oppressive body size norms, she may still eat and exercise in certain ways, purchase certain products and services, and perhaps even structure her life around the value of thinness. These choices middle-class white women make "make sense" to some extent given the cultural value of thinness, but over time, these choices, skills, and habits that people develop become a central part of a person's life and can shape their identity. This becomes a problem when the culture is an ideology that needs to be changed.

2.3. Cultural values are not always knowingly or willfully supported

Cultures are self-organizing and therefore do not require a central authority to be preserved. In fact, people are often unaware of the ways in which they uphold a particular culture even if it's harmful. Some people support harmful ideologies even when they value social justice (Young 1990; Haslanger 2017). This is because an ideology, since it is so deeply ingrained, informs and structures our practices and frames our identities in relation to these practices. So, many ways in which fat oppression manifests itself in society (e.g., when public health policies and initiatives place undue emphasis on the individualized responsibility of people to achieve or maintain "normal weight") are unknowingly being validated by people who have internalized the values, messages, and assumptions that give rise to these injustices (e.g., by exercising and eating in particular ways to maintain a "respectable" weight). People do not consciously participate in these patterns of learned behavior; they evolve in response to the environment and culture they are in so that they can effectively communicate, coordinate, and manage the things they take to have value, which is also informed by the culture.

Ideological oppression is perpetuated even by people who are subordinated by it. In order to participate in society, one must become culturally fluent and develop skills for interpretation, interaction, and coordination and doing so requires one to participate (often unthinkingly) in the

system that reproduces injustice (158). However, this is not to say that people who participate in their own subordination are "cultural dupes" – in fact, they may be "active, [and] sometimes skilled users of culture" (277). Again, participation in the system often makes sense (even for those who are subordinated by it) and seems called for, and their participation may be chosen autonomously (Khader 2009). The problem with having even those who are subordinated by the system participate in it is that it further entrenches the system that much more.

For example, people in larger bodies are often trying to lose weight and are even willing to go to extreme measures to lose weight. Given the prevalence and severity of anti-fatness and the persistent message that losing weight is achievable, people in larger bodies who diet can't be blamed for their actions – they seem called for. Their choices are consistent with the actions of most people, the concerns of "obesity" being expressed by government health agencies, the information shared in the media, and with the recommendations by health care providers – they are acting in a way that makes sense and is validated by the ideology. Some people in larger bodies – e.g., fat activists – are aware that their choice to diet, take weight-loss medication, or get bariatric surgery is heavily influenced by a system of injustice that makes them feel less valuable and worthy. However, a great majority of people in larger bodies have internalized their oppression and the message that the problem is not with society but rather, resides within them.

2.4. A deeply embedded culture reproduces itself and can be resistant to change

Another feature of culture is that it has a "looping effect" (Haslanger 2017, 2023). Looping effects are a central feature of systemic injustices and for that reason, we should understand ideological oppression as a systemic injustice (Haslanger 2023, 8). Ideological oppression is a systemic injustice because the network of social practices – or patterns of learned behavior – that make up social structures *reproduces itself* even in spite of outside disturbances (Haslanger 2023).

We all go through a process of social learning where we pick up on and begin using the relevant rules, norms, tools, social meanings, skills, and patterns of behavior that constitute social practices in order to effectively interpret what is taken to be valuable, communicate with others, coordinate various aspects of our lives, and manage the things that we care about. Over time, people are shaped to willingly adopt the social practices and find them to be valuable, thereby further entrenching them. As a result, the world is shaped to fit social meanings that make up our social practices, and social meanings then appear to reflect what we see in the world

thereby justifying them (Haslanger 2019). For example, an adolescent in a larger body may not receive a quality education due to incessant bullying from peers, having to navigate an environment that does not accommodate her size, and being unfairly evaluated by her teachers due to anti-fat prejudice. This should not be taken to mean that people in larger bodies are unmotivated, incompetent, disobedient, or unreliable. However, in this way, the world appears to confirm our anti-fat biases and stereotypes and the appropriateness of these stereotypes. This looping effect makes ideologies difficult to challenge.

Despite being resistant to change, systems sustaining ideologies have the ability to adapt to disturbances, evolve, and learn over time (Haslanger 2023, 8). Because there is no central authority guiding the system in one way or the other, it has the ability to self-adapt to outside disturbances while maintaining injustice. For example, holding explicit anti-fat attitudes, simply because it was deemed disgusting or wrong, was common in the 1990s and early 2000s. For example, consider this tweet by writer Lucy Huber (2021) that went viral: "If any Gen Z are wondering why every Millennial woman has an eating disorder it's because in the 2000s a normal thing to say to a teenage girl was 'when you think you feel hungry, you're actually thirsty so just drink water and you'll be fine.'" Also, consider this quote from a *Glamour* magazine article, titled "If You Survived the Early 2000s Without Body Issues, Congratulations":

> For millennial women, our formative years were a perfect storm of body-shaming forces culminating to catch us in the crossfires: the so-called heroin-chic fashion era that gave way to unforgiving low-rise jeans and baby tees, the advent of sites like Tumblr that allowed "thinspo" and "pro-ana"content to spread like wildfire, and the unprecedented anxieties of being the last generation to remember pre-internet life and be the first to come of age with the pressure-filled world of social media. (Konstantinovsky 2022)

These quotes illustrate how the late 1990s and early 2000s were different from today's culture in that body standards are a little more reasonable and our society has become a little more size inclusive than before. Millennials underwent a unique kind of "shared generational pain" where skinness was the standard of beauty *and* "the physical manifestation of discipline, dedication, and effort" (Ibid.). The *Glamour* article goes on to say that millennials "were told from every angle that weight was somehow correlated with morality and value" (Ibid.).

Pop culture, however, was not the only source of harmful messaging. As mentioned in the previous chapter, in 1998, the NIH lowered the maximum limit for "normal" weight on the

BMI scale from 27.8 for men and 27.3 for women to 25 for both men and women (Saguy 2012). It was also in the late 1990s that the diet drugs Fen-Phen (the popular name for the combination of fenfluramine and phentermine) and dexfenfluramine became popular. Despite evidence suggesting that dexfenfluramine could increase the risk of an untreatable and fatal heart condition – pulmonary hypertension – the FDA approved it because it was helping people lose weight and obesity was perceived as a threat to public health (Kolata 1997). In 2001, Surgeon General Dr. David Satcher delivered a call to action in an attempt to prevent and decrease the number of overweight and obese Americans. In his call to action, the Surgeon General delineated five major principles. These principles included "[promoting] the recognition of overweight and obesity as major public health problems" and encouraging Americans to eat a healthy and balanced diet and to get enough exercise in order "to achieve and maintain a healthy or healthier body weight" (Office of the Surgeon General (US) et al. 2001). These events in medicine and public health did not exactly challenge the messages that were being circulated in the media.

Today, society today has become a little more size inclusive – e.g., with the trending body positivity movement, the presence of plus size models, and more diverse clothing sizes – and public health policies and initiatives are attempting to place more emphasis on social determinants of health and less emphasis on individual behaviors in explaining the cause of obesity. While this is progress, there is still much pushback against being accepting of certain larger bodies – bodies that are ambiguously deemed "too fat." Fat oppression has not disappeared – it is still very much alive. It has merely adapted to society's evolving values and has done so in a way that seems justified, making it seem impervious to criticism.

2.5. An ideology is a two-pronged problem

When we understand systems of oppression as resistant to change and adaptive, it becomes clear how an ideology can be very difficult to change. There are several features of ideological oppression that make achieving justice challenging, but the difficulty really comes down to the ways in which people's values, practices, and identities are being shaped by the ideology. It is for this reason that the oppression seems justified and that many people don't even recognize the oppression as such. So, ideological oppression is not only *morally problematic* in that it perpetuates unjust conditions, but it is also *epistemically problematic* in that it distorts or misrepresents the morally relevant facts. But these two concerns – the epistemic and the moral – are inextricably tied. We cannot correct the moral concern without also correcting the epistemic.

This is because a great number of people are deeply immersed in the ideology and as a result "fail to appreciate what they are doing or what's wrong with it, and so are often unmotivated, if not resistant, to change" (Ibid., 152). In this way, collective epistemic failings are at least in part contributing to the perpetuation of oppression.

In the context of ideological oppression, an epistemic injustice occurs because an ideology has distributed power, resources, and knowledge in a way that prevents us from recognizing what is morally relevant and in a way that seems justified (Haslanger 2017). Rather than understanding the source of epistemic injustice in cases of ideological oppression in systematic prejudice or systematic hermeneutical marginalization, or a little bit of both, we can provide a far less complicated explanation by identifying the ideology that is responsible for the injustice. Additionally, locating the problem in an ideology as opposed to a prejudice – which is generally thought to be an *individual's* problem and responsibility to correct – we can recognize that the solution isn't as simple as calling upon agents to practice certain epistemic virtues (Fricker 2007). In a society that is deeply immersed in a problematic way of thinking will not think that they even need to practice epistemic virtues because they don't see a *moral* problem with their way of thinking. Moreover, even those who recognize the moral problem with fat oppression cannot bring themselves to support the fat acceptance movement because they can't get past the health reasoning/justification for anti-fat sentiments. This is where I think most people in today's culture fall – they recognize that fat shaming and weight discrimination is wrong, but they still think it's bad to be fat. It is our collective epistemic failings – due to our commitment to an unjust culture – that is contributing to the epistemic injustice that people in larger bodies are experiencing. To address the epistemic injustice, we must critique the culture "in terms of its contribution to a morally problematic system of social organization" (Haslanger 2017, 164).

3. Neglected Features of Epistemic Injustice & Their Role in Reproducing Injustice

Once we understand that much of the epistemic injustice that people in larger bodies experience is a result of a deeply entrenched ideology – i.e., the medical model – that is producing systemic injustice, we can see how some relevant features of epistemic injustice have been neglected by social epistemologists. In this section I will explain why paying more attention to certain aspects of epistemic injustice – namely, credibility excess, the comparative/contrastive quality of credibility, and the extensive harms of epistemic injustice that prop up the system of

injustice – make way for understanding how the (systemic) injustice is reproduced. This more comprehensive understanding of epistemic injustice allows us to get a better sense of how knowers are constructed through social and cultural practices, which is important for interrupting the cycle of injustice (Haslanger 2019).

3.1. Credibility Excess: Its Extensive Harms & Role in Sustaining Fat Oppression

Testimonial injustice was originally coined to describe a situation in which a *speaker* is wronged as a knower insofar as they are assigned *less* credibility than they should as a result of identity prejudice (Fricker 2007). For this reason, credibility *excess* has precluded from playing a role in certain accounts of testimonial injustice because it is assumed that a speaker is not harmed when she is given *more* credibility than she otherwise would be due to a *positive* identity prejudice. An overly narrow understanding of testimonial injustice also occurs because the analysis focuses on "individual moments" of testimonial exchanges rather than the *broader social context* in which they occur (Fricker 2007, 21; see also Medina 2013). While credibility excess could be harmful in some *cumulative sense* in that a person could, for instance, develop epistemic arrogance, it is not a testimonial injustice in that individual moment. Moreover, credibility, because it's not a finite good, is not something that needs to be distributed fairly (Fricker 2007). Therefore, assigning credibility excess to some individual or group of individuals need not harm others in a given context.

This overly narrow analysis fails to recognize that cases of testimonial injustice are a part of a larger systemic injustice. To get a more complete picture of the way in which credibility excess can be harmful, we need to broaden the scope of analysis to encompass others in the testimonial exchange as well as the broader social context in which it's taking place (Medina 2013). It's when we broaden the scope of testimonial injustice that we come to recognize that the injustice cannot be isolated to individual moments because it is systemic.[51] Given the self-organizing, self-reinforcing, and adaptive nature of systemic injustice, a testimonial injustice that

[51] Haslanger (2023) draws a clear distinction between structural injustice and systemic injustice. She thinks it is important to draw this distinction because while different societies may be structurally similar to one another, they differ in the details. When we have a clear understanding of what makes up social structures, we can recognize how structurally similar societies have slightly different ways of organizing relations and different social practices, which will affect how the relations that structure the society are instantiated. What's interesting about this distinction between structural and systemic injustice is that theoretically, there can be structural injustice without systemic injustice. However, Haslanger says, "I'm not really sure what that would look like, but I don't want to rule it out" (23). So, we can understand all existing structural injustices that are of interest to Fricker as *systemic*.

occurs within the system cannot be appropriately understood or addressed in isolation. We have to pay attention to the processes in which social and cultural practices shape knowers, not just the ideology itself.

For example, in the context of fat oppression, credibility excess is often assigned to well-meaning health care providers (HCP) – particularly esteemed doctors – who are deemed the experts or authority figures on labeling, understanding, and managing fatness (Ho 2011). Bestowing doctors with unfounded and disproportionate trust can be harmful in that it may encourage the epistemic hierarchy already in place and discourage dissenting voices. We frequently put unfounded and disproportionate trust in doctors because we assume they are experts given that they have met the rigorous prerequisites required to become licensed HCPs. This is not to say that putting trust in doctors is always irrational or shouldn't be done, but that we should recognize the ways in which they too are fallible humans.

We often assume that if doctors have all the medically relevant information about their patients, new research, methods, or protocols, they wouldn't make errors in understanding the cause, the solution, or the seriousness of a given condition (Peña-Guzman and Reynolds 2019). But this assumption ignores the ways in which doctors may misapply their knowledge due to their values, biases, and assumptions. For example, consider the way in which anti-fat biases and assumptions negatively influenced the medical care that a retired sixty-six-year-old patient received when we visited the doctor due to randomly and rapidly gaining weight despite eating very little:

> He told the doctor he wasn't eating but was continuing to gain weight. The doctor out-and-out *didn't believe him*. He said, "*Here's a diet. Come back in three months.*" Eventually my dad went to the hospital and they pulled twenty-seven pounds of fluid out of his abdomen. It turned out he had hemochromatosis…It's a simple blood test to diagnose, and once they find it they can treat it and you can live a long life. But because he was sick for a year before he was diagnosed or treated, my dad got liver disease and died eighteen months later. I feel he died of malpractice, but *I couldn't prove he didn't overeat* while he had twenty-seven pounds of fluid in him. I couldn't even get an attorney to take the case. Our society is so sure it's all about calories in, calories burned. *The relationship between health and weight is so complex, and we try to make it simple. And that hurts people.* (Brown 2015, 20, emphasis added)

In cases like this, which are not uncommon (see also Wann 1998; Cottom 2019; Schoenfielder and Wieser 1983 for more examples), people in larger bodies are being harmed because their

HCPs are making assumptions about their behaviors, lifestyle choices, and levels of well-being. These assumptions are also made despite conflicting testimonies from their patients and despite having the relevant education and experience. While the doctors may know how to diagnose and treat hemochromatosis, their biases affect their ability to appropriately treat patients in larger bodies.

Credibility excess in these kinds of situations clearly harms people other than the speaker – namely, the patient. However, the harm goes even beyond the patient. Because credibility excess is often assigned to people in more privileged positions and to people whose ideas conform to the dominant narrative (given that the dominant narrative was created by and for people in privileged positions), when an excess degree of credibility is assigned to individuals it often operates in a way that maintains the status quo. Consequently, speakers belonging to a privileged identity who are assigned credibility excess "are likely to develop epistemic habits that protect established cultural expectations" and ignore or discredit those things that defy the cultural expectations (Medina 2013, 68; see also Alcoff 2006). Additionally, when credibility excess is consistently afforded to certain speakers, it may encourage the speakers to develop epistemic vices such as epistemic arrogance, epistemic laziness, and close-mindedness. For example, epistemic arrogance, or a situation where a speaker has an exaggerated sense of one's epistemic abilities, will likely produce a lack of "motivation and intellectual curiosity to probe the evidence more fully" and a resistance to see things from a different perspective (Medina 2013, 68).

However, since the perspectives of doctors typically conform to the deeply entrenched medical model, their perspectives don't get challenged and their epistemic arrogance is not even interpreted as such. A systemic understanding of testimonial injustice would acknowledge the ways in which social *practices* of doctors – which consists of uncritically employing the same social meanings, tools, scripts, assumptions to evaluate people in larger bodies – are contributing to the poor health of people in larger bodies, thus making their choices ideologically justified. On top of this, because society regularly affords medical practitioners and researchers with more credibility than they deserve, this only condones their epistemic vices and reinforces social practices that produce epistemic injustice.

3.2. Understanding Credibility as a Comparative Good Assigned to Conforming Testimonies

It has been argued that while it's true that credibility is not a finite good that needs to be justly distributed, it is a good that is *comparatively* distributed among individuals and is informed by identity prejudice (Medina 2013). Credibility judgments made about certain interlocutors in a testimonial exchange may affect the epistemic credibility, degree of authority, and self-confidence of others involved. This is because "[c]redibility never applies to subjects individually and in isolation from others, but always affects clusters of subjects in particular social networks and environments" (Ibid., 61). We evaluate people's credibility in comparison to others – we compare and contrast credibility among races, genders, sexual orientations, or other bodily features. The level of credibility assigned to individuals will also likely depend on the content of the speaker's testimony. Generally speaking, a person whose testimony challenges the dominant narrative will receive comparatively less credibility than a similarly situated person whose testimony corroborates the dominant narrative.

This comparative nature of credibility also comes into play when considering the content of a speaker's testimony. While it is likely the case that a non-fat person is generally afforded a greater degree of credibility than their larger-bodied counterparts, the content of the testimony and the social context will also influence their degree of credibility. When the testimony of a marginalized individual corroborates the ideology, they will likely have more credibility than a marginalized individual who challenges it. Similarly, the testimony of a privileged individual corroborates the ideology, they too will have more credibility than another privileged individual who challenges it.

3.2.1. Degrees of Credibility Among Doctors

As demonstrated in the previous chapter, obesity researchers get away with making anti-fat assumptions about fatness, and this is often because they are experts in their field and the assumptions made in their research stem from a deeply embedded ideology. However, even experts in obesity research (e.g., Katherine Flegal, Carl Lavie) are judged in relation to the social imaginary around fatness. Researchers who challenge the medical model receive comparatively less credibility and their perspectives don't get much uptake (at least not without excessive backlash). Recall, for instance, the harassment that the prominent obesity researcher Katherine Flegal experienced as a result of her research (see Flegal 2021), which showed being

"overweight" is most protective against mortality and that the mortality rates for people who are "mildly obese" are the same as those who are "normal weight" (Flegal et al. 2004).

The credibility of Flegal's work was disproportionately criticized compared to that of Mokdad et al.'s (2004) work. Despite consistently flagging the strengths of their work compared to others, explaining why their estimates for mortality were more accurate than previously reported, and even after defending the results of their study in various subsequent publications (e.g., Flegal et al. 2013), Flegal experienced years of unrelenting and unwarranted criticisms. This is in part due to the content of what Flegal was saying, but what made the content of what Flegal said so controversial may also be a result of social practices in biomedical research and publication. For example, it has been argued that social practices in medical research have influenced the information that is publicized and the way it is presented (Cope and Allison 2009; Boutron 2019; Boutron and Ravaud 2018).

3.2.2. Degrees of Credibility Among People in Larger Bodies

The idea of incorporating fat activists in "obesity research" is likely discouraged because fat activists have a biased, political agenda. But this way of labeling and dismissing their value-based resistance ignores the ways in which we all bring our values and experiences to bear on what we think matters in research. Chapter 2 demonstrated that the widely held "concern for health" is not really motivating the decisions of obesity researchers – that is, researchers have an alternative (or additional) agenda. I argued that the agenda of obesity research has been skewed in the interests of the medical model framework, so incorporating the perspectives of people in larger bodies with fat-positive testimonies would actually improve research by engaging with conflicting ideas from people who have the most to lose. Nevertheless, the proposal to incorporate fat activists faces resistance not simply because of identity prejudice but because they explicitly renounce the medical model and are therefore thought to be "promoting unhealthy lifestyles."

Thus, the testimonial injustice that fat activists experience is at least in part due to the fact that the content of their testimonies directly challenges the ideology. Since most people use the dominant epistemic resources that are provided by the medical model, these resources are unable to make the testimonies of fat activists intelligible (Pohlhaus 2011; see also Medina 2013). The epistemic failings that accompany those in the grip of the ideology (Haslanger 2017) cause hearers to ignore or misconstrue the testimonies of fat activists. This may occur as a result of

willful ignorance (Pohlhaus 2011), but in the context of fat oppression it's not so clear that the problem is simply ignorance. Rather, at least part of the problem is that these knowers are being constructed through social and cultural practices that are informed by an oppressive ideology. As Haslanger puts it, "Explanations that rely simply on the ignorance or vices of particular individuals are unsatisfying because at least part of the problem lies at the social rather than the individual level. At the heart of this pattern is a structure of social relations that is ideologically sustained" (Haslanger 2023, 2). The coordination system that structures the social practices – i.e., the network of meanings, tools, scripts, schemas, assumptions, models, that medical researchers and practitioners share and employ – in the medical community that reinforce and further entrench the medical model is the problem that needs to be addressed for justice to ensue.

3.3. Extensive Collateral Harms & Their Role in Preserving Structures of Oppression

Analyzing the epistemic harms of the social imaginary of fatness is also best understood from a broader systemic perspective because this approach accounts for the extensive, collateral harms that the ideology reproduces. Though non-fat people are not oppressed by fatphobia (but rather benefit from it), they nevertheless experience collateral, systematic harms as a result of fatphobia. These extensive harms are *another* way in which fat oppression is reinforced.

In her attempt to differentiate cases of testimonial injustice – or cases where identity prejudice causes a hearer to attribute the speaker with less credibility than they ought to receive – from cases of epistemic injustice that do not occur as a result of identity prejudice, Fricker (2007) uses the term "epistemic bad luck." Epistemic bad luck occurs when a hearer employs a kind of justifiable stereotype (i.e., "an empirically reliable stereotype") that is actually, unluckily, misleading in the given context (Ibid., 30). She does not deny that these situations are harmful, but she describes them as accidental, one-off situations in that they do not further oppress individuals who lack social power. The way Fricker conceptualizes epistemic bad luck and the examples she gives of epistemic bad luck have been controversial. Fricker considers the example of Joe, a cis-het white man whose experience of being stalked is disbelieved by law enforcement, as a case of epistemic bad luck rather than one of hermeneutical injustice.

Fricker's use of epistemic bad luck conceptually cuts off the possibility of other forms of epistemic injustice because it is framed as an antithesis to epistemic injustice (Dotson 2012; Berenstain 2020). Thus, all situations in which someone is wrongly given less credibility than

they deserve, that do not fit the description of epistemic injustice, resort to being categorized under the label "epistemic bad luck." However, calling Joe's experience an example of epistemic bad luck completely overlooks "the role that rape culture and norms of toxic masculinity under cis-heteropatriarchy play in producing the interpretive harm that Joe experiences" (Berenstain 2020, 737). Even though Joe is not *oppressed* by white cis-heteropatriarchy (but rather, benefits from it), he (as well as other men) is *systemically and collaterally harmed* by it. Additionally, because it is a systemic harm, what Joe experiences is not a one-off but rather, an example of the recurring harms men may experience as a result of patriarchy. Another example of how patriarchy inadvertently harms men is in the way violence committed against men is ignored and rarely reported (because admitting it is shameful and *unmanly*) (Svrluga et al. 2015). With sexual harassment and assault against men rarely discussed and men too embarrassed to report it or afraid they will not be taken seriously, patriarchy preserves itself. This too is an example in which society's culture and norms all too conveniently preserve structures of oppression.

Understanding epistemic bad luck the way Fricker does has similar undesirable consequences in the context of fatphobia. For example, imagine a group of cisgender male non-fat co-workers sitting down at a restaurant for lunch. While discussing what to order, the co-workers eventually begin talking about things like what foods they're avoiding, what exercise regimens they're trying, how far they ran this morning, and how much they've been lifting. They talk about how much weight they've lost or how much (more) they're trying to lose. The conversation eventually shifts to the topic of the "obesity epidemic" and how terrible it is that so many Americans are overweight. They say, "Why don't people just eat less/healthier and exercise more?" Every person at the table, though they aren't fat, is being harmed by this conversation that perpetuates harmful assumptions about fatness and stereotypes about people in larger bodies. These conversations preserve the system of oppression by cautioning non-fat men against becoming fat (Reiheld 2018).

For this reason, Alison Reiheld (2018) argues that we should expand our current use of the term *microaggression* to describe what is done to people *targeted*, because other people are also systemically harmed by these microaggressions. She argues that expanding the concept of microaggressions can help us make sense of how "microaggressions directed toward fat people have the additional consequence of also harming those who are not (yet) fat" (205). By expanding the concept of microaggression in this way, we can then see how microaggressions

have the additional feature of "propping up" or preserving fatphobia by cautioning non-fat people against becoming fat (Ibid. 206). The ability for people to waver between "fat" and "non-fat" plays a major role in the nature of anti-fat microaggressions because these microaggressions target both the unruly body and the *behaviors* that presumably cause the unruly body. Microaggressions also harm non-fat people by targeting their appearance and behaviors – they teach non-fat people to not go beyond some arbitrary weight threshold, dress size, BMI, etc. and to avoid certain behaviors that are believed to contribute to fatness (Reiheld 2018).

The most familiar and harmful way in which non-fat people are harmed by fatphobia qua non-fat people is through development and preservation of eating disorders.[52] Everyone is affected by the explicit messages from the media, friends and family, health care practitioners, and public health campaigns about how unhealthy it is to become "overweight" (also known as "pre-obese") or "obese." All people (including women of color, trans and queer folks, disabled people, men, and adults), though for different trauma-based reasons, are capable of developing eating disorders, and these messages about health merely justify and perpetuate their coping mechanisms in response to the trauma. For example, Virgie Tovar (2018, 6) describes one email she received from a woman who was being treated for bulimia and how "[e]ven though she was seeking treatment for a disorder that threatened her very life, she was still cautioned against gaining 'too much' weight while in recovery." This fixation on body size and body weight suggests that recovery is good only insofar as it doesn't make one fat.

4. Objection: What About Fat-Negative Testimonies?

Though fat activism – and subsidiary movements like body positivity or size inclusivity – are growing in popularity, most larger-bodied people still dislike their bodies and often have a *strong* desire to lose weight. Even fat activists experience moments of shame and discomfort with their bodies as a result of living in a fat phobic society:

> At those times it doesn't seem fair to me that I have to always be fighting to be happy. *Would it be easier for me to just give in and go on another diet so that I can stop this perpetual struggle?...* I know that's not the answer and I could never

[52] There are two important points to make here. One, people in larger bodies frequently experience eating disorders (though it's a common assumption that people in larger bodies cannot be, for example, anorexic due to their weight). People in larger bodies may arguably be harmed to an even greater degree than their non-fat counterparts because they often experience longer durations of symptoms, greater levels of weight loss, and increased distress as a result of misdiagnosis, delays in care, or avoidance of healthcare (Harrop 2019). And two, non-fat women as well as trans and queer folks may very likely develop eating disorders because they are oppressed *as women, trans, and queer folks* – they are *not* oppressed *as non-fat people*.

> do that to myself, but *I can't say that the thought never crosses my mind*. (Lamm 2019, emphasis added)

Roxanne Gay (2017) similarly has second thoughts about what is in her best interest – changing herself to become respected and loved or trying to change society:

> Intellectually, I recognize that I am not the problem. This world and its unwillingness to accept and accommodate me are the problem. But I suspect it is more likely that *I can change before this culture and its attitudes toward fat people will change*. In addition to fighting the "good fight" about body positivity, I also need to think about *the quality of my life in the here and now*.

If even fat activists, who dedicate much of their lives to fight size-based discrimination and weight stigma, oscillate between fat pride and shame, it should not come as a surprise that people in larger bodies generally do not (always) feel proud and happy with their bodies.

Thus, given the abundance of fat-negative testimonies by people in larger bodies, one might ask why we should consider the epistemic injustices that people in larger bodies experience as a *systemic* epistemic injustice. If people in larger bodies are generally unhappy with being fat and want to lose weight, then it may seem inappropriate to describe promoting the medical model or the dominant narrative surrounding fatness as a systemic epistemic injustice. Rather, it may be more appropriate to describe the cases of epistemic injustice that fat activists describe as mere instances of epistemic injustice. If we think all people in larger bodies – regardless of how they personally feel toward their own bodies – are experiencing epistemic injustices, wouldn't that ignore all fat-negative testimonies and thus, be a kind of testimonial injustice?

4.1. Fat-Negative Testimonies from People in Larger Bodies

People in larger bodies who hold mostly (or exclusively) fat-negative sentiments should not be discounted because they are thinking or acting reasonably in response to pervasive anti-fatness. Additionally, they are also a part of the oppressed group and as such, deserve to have their voices heard. If we were to exclude any and all people in larger bodies who have fat-negative testimonies, we would not be able to develop an inclusive theory of fatness.

The central question that we should ask people in larger bodies with fat-negative sentiments is whether they developed the sentiment as a result of prevailing anti-fatness. In other words, do they hold anti-fat sentiments because they have internalized their oppression? If people in larger bodies are holding anti-fat sentiments as a result of viewing their own bodies as

well as other larger bodies through the lens of the medical model, then these testimonies do not undermine my argument that people in larger bodies experience systemic epistemic injustice. Internalized oppression, or the experience of "double-consciousness," is a feature of systemic epistemic injustice. When the dominant narrative is powerful and pervasive, it can be difficult for people to maintain their subjectivity – they come to view themselves through the dominant lens. As opposed to other oppressed social groups such as Black people or women, people in larger bodies have difficulty loving their body that has been systematically labeled as *diseased*. While being openly racist or sexist is no longer condoned, being openly anti-fat is condoned because it's disguised as a concern for health. Internalized fat oppression has a particularly tight grip on people in larger bodies because "disease" is attached to their bodies in a way that cannot be easily denied in our culture because it is presumed to be grounded in impartial science (Young 1990). When body norms were brought into the science discourse, it "naturalized them, gave the assertions of superiority an additional authority as truths of nature" (Ibid., 127). This authority just further fuels the aspiration to assimilate, fit in, and be viewed as a respectable participant in society.

The moments of shame and despair described by people in larger bodies are rarely a result of one's body (i.e., fatness itself) but rather, a result of the way one's body is perceived and treated in society. This, of course, does not mean that all fat-negative sentiments held by people in larger bodies are caused by anti-fat stigma and discrimination – they may in fact be caused by fatness itself. In other words, I do think there are cases where even in the absence of anti-fatness, people in larger bodies would still view fatness as a bad thing, as I will discuss in more detail in the following chapter. However, the reason these people view fatness as on the whole a bad thing in their lives is because being in a larger body has frustrated their attempts to pursue their dreams, hopes, and desires. For example, if a person's foremost dream is to become a professional ballerina, but this dream is frustrated by her fatness – not because the dance industry discriminates against body size (which it does), but because her body prevents her from being able to dance "en pointe"[53] – then in this case, the person would rightfully say that fatness itself has an overall negative effect on her well-being.

[53] This example is inspired by a real-world example of a larger bodied ballerina named Chloe Elliott (Gray 2020). Of course, in this example, Chloe can dance "en pointe," or on the very tip of her toes despite the widely held assumptions that people of her size can't dance "en pointe."

I am not suggesting that these fat-negative testimonies that stem from fatness itself (and not from pervasive anti-fatness) should be ignored. However, I also don't think they undermine my argument that people in larger bodies experience systemic epistemic injustice. I have two reasons for thinking this. One, I think fat-negative testimonies that stem purely from the way in which fatness itself frustrates one's hopes, dreams, and desires are very few. This is because it's very uncommon for a person to say definitively that their fatness is what prevented them from pursuing their dreams. Even the example I gave about a ballerina not being able to dance en pointe is inspired by an example where a larger-bodied ballerina *could* dance en pointe despite the stigma and discrimination she encountered in the dance community. I also think it's difficult for us to say that fatness *itself* frustrates dreams and desires because it is often unclear if it's the fatness itself that causes the negative effects associated with living in a larger body or if social factors are playing a role. For example, a larger-bodied ballerina may think that one's body is preventing her from being able to dance en pointe, but in reality, it could be because she does not get the same quality instruction or support as other ballerinas in her class do. Additionally, since a vast majority of ballerinas are non-fat (and are actually quite slim), ballerina instructors may not know how to teach someone in a larger body how to dance en pointe or know the appropriate technique for someone in a larger body.

Second, I don't think the few instances in which we can say that fatness itself frustrates one's personal dreams challenges my point about systemic epistemic injustice. This is because even if fatness itself can be said to have an overall negative effect on a person's well-being, they may very likely still experience fat oppression. They may also internalize fat oppression. Those who are pretty adamant that fatness itself is a bad thing (and would be a bad thing even in a world without fat oppression) are often conflating the negative effects of fatness itself with the negative effects of fat oppression. As demonstrated in the ballerina example above, it's often difficult to separate what we think are negative effects of fatness itself from the negative effects of fat oppression.

4.2. Suspicious Testimonies: "Pro-anorexia"

There is a small subset of people in larger bodies whose non-fat testimonies should be cautious of taking seriously – namely, fat-negative testimonies from those within the "pro-anorexia" movement. Anorexia is, in short, a psychiatric illness in which an individual restricts their energy intake out of fear of weight gain and has a BMI ≤ 18.5. For this purpose of this

paper, when I refer to "anorectics" or "anorexia" I am including those who are defined, by the DSM-5, as those suffering from "atypical anorexia." Atypical anorectics suffer from the same condition as anorectics, but they have a BMI over 18.5. Therefore, this argument about the testimonies of pro-ana community members applies also to larger-bodied anorectics in the community.

Pro-anorexia is a "movement that supports those with anorexia and adopts an 'antirecovery' perspective on the disease" (Fox, Ward, and O'Rourke 2005, 944). Though, to clarify, the movement, as described by those who subscribe to it, is a movement that *supports the needs of anorectics*, it's not a movement that *supports anorexia*. As one member of a pro-ana internet community put it:

> [T]his board *SHOULD* be used for *pro-anorecticS*. *Not pro-anorexIA*. We should not be in favour of the disease that kills thousands of girls a year, rather in favour of the girls and boys who have this horrible disease and *help them the best way they can*…whether it be by giving support to start another fast or advice on the 'healthiest' way to handle low calories. Not to teach others how to die. (Fox, Ward, and O'Rourke 2005, 959)

I will say that I think this distinction between supporting anorectics and supporting anorexia is an important one, and it is quite similar to the message that fat activists are voicing – namely, fat activists are not encouraging other people to become fat nor are they promoting unhealthy lifestyles, they're simply asking for justice. Anorectics don't face injustice; however, they are seeking a different kind of support. The goal for these spaces is not to teach people *how to become* anorexic but to help people who are already anorexic to continue being anorexic in a safe way:

> I don't agree with promoting or encouraging anorexic tendencies at all. however, *I do agree with giving anorexics a place to go, a place to find support and learn about the disorder.* this way hopefully everyone will know how to do this as healthy as possible. the reason why anorexia is so hard to recover from is because it is just as much psychological and it is physical if not more actually. in the psychological sense ana makes you feel so alone, so depressed, completely isolated and unloved. pro-ana websites create a place for us to go, and talk with others and try and not feel quite so alone, however, sometimes even that isn't enough. (Fox, Ward, and O'Rourke 2005, 959)

As members of the online pro-ana community explain, most of them are not trying to lose weight to look better, *they admit to being sick* – one member of the community writes, "Anorexia is

defined as a mental disease . . . the ability to play mind-games with yourself relating to anything food or exercise" (Ibid., 955). Another member confirms this view by saying, "'*True anas*' have much underlying pain or desperation for power, besides their desire to look 'good'. After a while, the desire to look good goes away…" (Ibid., 957). And, again, another member says, "*Genuine sufferers* [are those] who are in pain and really do suffer from some mental affliction or illness related to food, eating, weight, etc." (Ibid.).

Members of the pro-ana support groups are looking out for the interests of "true anas" who are looking for support as they try to get through life with the eating disorder – they do not support those who are seeking out tips or "looking for a quick diet" (Ibid., 958). Members can tell who the "true anas" are because they see their eating disorder "as a sanctuary from the pain" that they endure and as something that gets them through life. Because they are so reliant on their eating disorders, they can't imagine giving it up. This is not to say that members of the pro-ana community are against recovery – rather, they just aren't ready to recover yet, and they don't support forcing people into recovery. As one member put it: "maybe one day I will be ready for recovery, but I certainly am not yet – and I am sick and I like to know there are people out there who feel the same way as me" (Ibid., 966).

These testimonies from members of the pro-ana community are, I think, enlightening. The pro-ana community does not support extreme dieting or encourage others to become anorectic. For this community, anorexia is a lifestyle that one has adopted to cope with life difficulties. What I find most interesting is that, like fat activists and disability activists, members of the pro-ana movement are challenging dominant conceptions of illness as something that needs to be cured. The pro-ana community challenges a "medical model" way of viewing anorexia because it understands recovery "as a simplistic solution to a symptom that leaves the underlying pain and hurt unresolved" (Ibid., 967). In other words, simply curing the physiological body will not cure the psychological condition that caused the physiological condition of the body.

As enlightening as these testimonies are, I do not think this kind of lifestyle should be supported for two reasons. One, members of the community (or at least some of them) admit to being sick and are open to the *possibility* of recovery but simply aren't ready yet. They use their eating disorder as a crutch to help them get through life that often feels unbearable and out of control. In other words, they recognize that it is an unhealthy and life-threatening coping

mechanism. Two, members of the community are not demanding justice, they are demanding support for their lifestyle. Anorectics are not oppressed *qua* anorectics. For example, Black women may develop eating disorders as a result of oppressive situations – e.g., as a result of unfair body/beauty standards, food insecurity, or sexual trauma – but they are not oppressed because they are anorectics.[54] Therefore, since members of the pro-ana community recognize that they are suffering from an illness that is serving as an unhealthy coping mechanism and they are not an oppressed social group (though may be a group that is composed of members of oppressed social groups), these fat-negative testimonies should not be taken anywhere as seriously as those coming from people in larger bodies.

In sum, while I don't think we should take the anti-fat testimonies from people in the pro-ana community (which may include larger bodied anorectics) seriously, I do believe we should take into consideration the anti-fat testimonies of people in larger bodies. However, I argued that these anti-fat testimonies are often the result of internalized oppression and not a result of fatness itself. For this reason, it lends support for understanding the epistemic injustice that people in larger bodies experience as a systemic epistemic injustice. I also argued that anti-fat testimonies provoked by the negative effects of fatness itself are few and far between and even those who can say definitively that fatness itself is what has caused an overall negative effect on a person's well-being are also very likely to still be the victim of fat oppression. Therefore, even if there are anti-fat testimonies, it does not take away from the fact that the epistemic injustices that people in larger bodies experience are systemic in nature.

5. Conclusion: What Does Epistemic Justice Call For?

What is unique about ideological oppression is that it is often not perceived as a kind of oppression because the ideology is so deeply ingrained that the oppression appears justified. Even once people begin to recognize the ideology and see the injustice it perpetuates, legislative,

[54] Not all people develop eating disorders as a consequence of oppressive forces, but they often develop them as a result of traumatic events. However, a lot of the time, these traumatic events are the result of oppression. In such cases, we should understand the injustice as contributing to an illness that is difficult to let go of because it gave them a sense of control and provided comfort during challenging times. It is not unreasonable for people to do this, but their fear of gaining weight, of not being able to exercise, and of eating are not healthy coping mechanisms.

For example, trans and nonbinary patients are far more likely to experience eating disorders than cisgender patients. This is in part because in addition to experiencing body dissatisfaction, trans and nonbinary people are also likely to experience *gender dysphoria*, or extreme physical and emotional discomfort caused by perceiving one's body as incongruent with their gender. Gender dysphoria is a unique experience that only trans and nonbinary people experience that makes one's body feel foreign, detached, or terrifying, and disordered eating may arise as an attempt to control a body's gendered characteristics in a cisnormative society.

judicial, and individual efforts to change it are often unsuccessful because of how deeply ingrained it is. In this way, the political injustice is tied up in the epistemic shortcomings that the ideology is instigating. The ideology is preventing people from recognizing what is actually valuable and for that reason, the culture cannot change. If fat oppression is being perpetuated via an ideology, then the solution isn't as simple as calling upon agents to practice the virtue of testimonial justice (Fricker 2007).

To make an effective change, we must understand how individuals become fluent in unjust practices and are taught to view such practices as natural. Practicing epistemic virtues will only take us so far because ideologies function to "block the development and/or exercise of the reflexive and critical capacities" of agents (Haslanger 2017, 161, quoting Celikates 2006). While unjust social systems are constituted by individuals, such individuals are, often unknowingly, interpellated to enact injustice through networks of learned patterns of behavior, which are shaped by cultural norms, beliefs, and values (Haslanger 2022).

I argue that the source of the problem is the ideology that is the medical model. How do we get rid of an ideology? The ideology cannot just be thrown out, it has to be *replaced* with a different set of cultural tools and skills (Haslanger 2017). In some, more favorable circumstances, an ideology has a better chance of being changed due to social support of the cause and people willing to be open-minded. However, the new culture must be something that is more just and viewed as something that is generally in everyone's best interest (Ibid.). This will be helpful in garnering support in resisting the ideology. Additionally:

> Effective social change must not only provide incentives for acting differently, for example, through law or policy, but must replace the problematic practices and the meanings that partly constitute them with alternative meanings that have some *continuity with the prior meanings*, so we can *project ourselves into the new practices and new form of life*. (Haslanger 2017, 159)

In order to promote an alternative option that people can get behind and that is practical, there needs to be some kind of consistency. For example, we can still value health, but our understanding of health will need some restructuring. Justice will require "a restructuring of our practices so that we are positioned to recognize the value of new or different kinds of thing [*sic*] and coordinate on just terms" (169). Fat liberation, more specifically, will require that we restructure our practices revolving around food, exercise, health, and the body to be more size

inclusive. In the following chapter, I propose that we replace the medical model with a value-neutral model of fatness.

In order to replace our problematic social practices with those that support a value-neutral model of fatness, we must advocate for it. This is where things like education and activism will play an essential role. It is also the point at which practicing epistemic virtues will be beneficial. To challenge, resist, and reconstruct the dominant narrative of fatness, beneficial epistemic friction is needed. Epistemic friction is a kind of epistemic resistance to the dominant narrative – it is "a friction that enables us to acknowledge and engage alternative viewpoints and to reach epistemic equilibrium among alternative perspectives on a problem or phenomenon" (Medina 2013, 176). Examples of engaging in epistemic friction include "forcing one to be self-critical, to compare and contrast one's beliefs, to meet justificatory demands, to recognize cognitive gaps, and so on" (Medina 2013, 50).

In the last chapter, I will expand on these initial thoughts on making progress toward fat liberation. Before that, in the next chapter, I propose that we replace the medical model of fatness for a value-neutral model of fatness. I will argue that since we have to assume that being fat is suboptimal (i.e., assume the very idea that is up for debate) and we don't have good enough evidence for thinking that fatness itself is inherently suboptimal or bad, we ought to take people in larger bodies as good sources of evidence about what it is like to be fat (Barnes 2006). Moreover, given the growing numbers of fat-positive testimonies, we need to seriously consider the perspectives of fat activists. If fatness were a bad-difference (as most assume), fatness itself would automatically make a person worse off even if the society were just and fully accommodating of fat bodies. However, we don't have good enough evidence for thinking this, particularly given fat-positive testimonies.

Chapter 4: The Value-Neutral Model of Fatness

This far I have argued that the medical model of fatness has perpetuated the oppression of people in larger bodies through the means of cultural imperialism. The medical model has played an illegitimate role in obesity research, and its problematic assumptions are deeply entrenched in policies related to public health as well as clinical care for people in larger bodies. Moreover, obesity research and the health-oriented ecosystem around it have been used to justify fat oppression, despite the first-person testimonies of people in larger bodies regarding their health and well-being. In the last chapter, I demonstrated how anti-fat assumptions influence who is considered a knower, whose claims are accepted within the epistemic community, and how this systematically influences the distribution of knowledge and ignorance and perpetuates fat oppression.

In an attempt to alleviate the harms that accompany the medical model, in this chapter, I propose a new way of perceiving fatness and subsequently people in larger bodies – i.e., a *value-neutral approach to fatness*. I employ a value-neutral model of disability proposed by Elizabeth Barnes (2016) to argue that similarly, fatness ought to be regarded as neutral with respect to well-being.[55] In making this argument, I also demonstrate how the value-neutral approach to fatness even considers the bodies of those who are "infinifat" or those who we can say for certain are "unhealthy" because of their body size as value-neutral. I argue that this value-neutral framework is appropriate in explaining why we should not assume fatness is (1) in itself or (2) on the whole, a bad thing, and by assuming that it is, we run the risk of oppressing even those we can reasonably assume are unhealthy because of their weight.

I follow-up this argument with a potential objection which arises from a variation of the adaptive preference argument. One may say that due to the strong association made between "morbidly obese" and unhealthiness, first-person testimonies of fat activists and their arguments for fat acceptance should be dismissed, because why would anyone prefer to be fat over not being fat? Some may think that anyone who says they prefer being fat is delusional in these cases and has lowered their preferences to suit their limited options (i.e., fat activists of this size must have an adaptive preference for being fat). In response to this objection, I will argue that this is

[55] I am not the first to apply a constructionist model of disability to fatness – e.g., see Cooper (1997). Later I will mention some of the other literature in disability/fat studies that argue in favor of merging these two areas of study.

not a case of adaptive preference and those who say otherwise are assuming that fatness is a suboptimal state. Their charge, I claim, inflicts epistemic injustice.

1. The Social Model & Its Shortcomings

Disability activists and scholars have historically promoted a social model of disability (Oliver 1996), which makes room for their disability-positive testimonies, as opposed to a medical model of disability (e.g., see Boorse 1976), which views disability as a problem with the body that requires treatment. An appropriate understanding of the social model of disability relies on the distinction between impairment and disability. An impairment is considered "nothing less than a description of the physical body" (Oliver 1996, 35). In contrast, a disability is the "disadvantage or restriction of activity caused by a contemporary social organization which takes no or little account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities" (Ibid., 22). This distinction clarifies that an individual's impairment needs not be a negative thing but rather, the disabling environment and social context in which she lives can be oppressive and negative. This model understands disability as a social construction and emphasizes the need for social change in order to address the disadvantages of disability.

One problem that has been raised in response to certain kinds of social constructionist views of disability – e.g., the social model – is that they tend to hold that "[d]isability *just is* the negative net effects of having an impairment in a society that discriminates against those with impairments (Barnes 2016, 25, original emphasis). In other words, proponents of the social model think all (or at least most) of the negative experiences that come with having an *impairment* are actually associated with the negative experiences of living in an ableist society (i.e., they come with the *disability*). This means that if we lived in a non-ableist society, these negative experiences would be mostly gone, because disabilities wouldn't exist. Impairments, however, would still exist, but they would not be disabling.

The social model makes an assumption that there are some common feature(s) present in all bodies with impairments. Similar to the medical model and its difficulty in defining disability, the social model will run into trouble trying to define impairment in a way that unifies all atypical bodily conditions that normally fit into that category. For example, the CDC defines impairment as "an absence of or significant difference in a person's body structure or function or mental functioning" ("Disability and Health Overview | CDC" 2020). The problem with this

definition (as well as all other definitions of impairment) is that it overgeneralizes. To explain this problem, Barnes (2016) writes:

> The main problem with these accounts…is that there are many disabilities that aren't correlated with a specific lack of ability. Some conditions we class as disabilities have fluctuating physical manifestations—you may be unable to do something one day, perfectly able to do it the next. And conditions that affect energy levels or cause chronic pain often don't cause the lack of any one particular ability, though they may affect how quickly you can perform a task, whether you can perform the task pain-free, or how much you can do in a given time period before needing to rest. There isn't always a neat correlation between disability and de re lack of ability. (16-17)

These problems that affect both the medical and social models of disability lead Barnes to claim that "there's no objective feature(s) that all and only disabled bodies share" (Ibid., 37).

But why do we even need a theory of disability? What purpose is there for categorizing people as disabled? Barnes believes that what makes the category of disability worthwhile and useful is when activists are "organizing themselves in a civil rights struggle" (Ibid., 41). The category matters for disabled people in order to make sense of, explain, and respond to the social oppression they experience. Disability activists have specifically organized to challenge the personal tragedy view of disability by *celebrating* disability and showing *pride* in their disability. That is, activists often promote an *affirmational account* of disability (Swain and French 2000).

This is where another problem with the social model of disability arises. Supporters of affirmational accounts of disability claim that the social model of disability is simply "redefin[ing] the problem," when what we should be doing is promoting a positive view of disability (Swain and French 2000, 570-571). In other words, the social model is still offering a tragic view of disability, but rather than associating the tragedy with the body or the *impairment*, they are associating the tragedy with the *disability,* i.e., with living under conditions oppressive to certain kinds of bodies. Because the social model understands disability as the "improper imposition of social norms upon bodies," supporters of the social model understand disability as being something that is negative (Barnes 2016, 42). As Barnes points out, "It's difficult to maintain, simultaneously, that disability is something to be celebrated and that disability is something we ultimately want to get rid of" (Ibid., 43). Consequently, it can feel somewhat confusing given that the mainstream understanding of "disability" is that it is embodied/individual. If you want to have pride in that, you can't want to eliminate it. It is for this

reason that Barnes argues "an account of disability needs to at least *leave open* that the affirmational characterization of disability increasingly common within that civil rights movement is correct" (Ibid., original emphasis).

2. The Value-Neutral Model of Disability

To avoid the problems of overgeneralization and epistemic injustice, Barnes (2016) proposes a kind of mere-difference view of disability that she calls the *value-neutral model*. The value-neutral model claims that disability is neutral with respect to well-being. In making this argument, it becomes clear that disability is not a unique social category – it is just like other social categories (e.g., sex, sexual orientation, race), all of which are "'mixed bags' with respect to well-being" (79).

2.1. Is Disability in Itself a Bad Thing?

The *mere-difference view* holds that living with disabilities may be a non-standard way of living, but it does not necessarily make a person worse off. One of the foundational claims of the mere-difference view is: "A principal source of the bad effects of disability is society's treatment of disabled people, rather than disability itself" (Barnes 2016, 70). This is not to say that this claim is unique to the mere-difference view. Supporters of the rival view – the *bad-difference view* – may also agree with this claim. The bad-difference view holds that having a disability would make a person worse off "even if society was fully accommodating of disabled people" (Ibid., 55). So, the point of disagreement between the bad-difference and mere-difference views of disability is the *degree* to which the bad effects come from society's treatment of disabled people as opposed to the disabled body itself and the significance of this (Barnes 2016). The bad-difference view can say that most of the negative effects of having a disability stem from the disadvantages that come with living in an ableist society while also holding that if these social disadvantages were gone, living with a disability would still be a worse way to live. Supporters of the mere-difference view challenge this claim by questioning whether we can prove that disability by itself automatically makes a person worse off. In other words, the mere-difference view challenges the presumed relationship between disability and well-being

The mere-difference view does not deny that disabled people, on average, have lower levels of well-being. Acknowledging this fact doesn't undermine the view. The point that supporters of the mere-difference view rely on is that a large majority of the negative effects that

accompany disability are the result of society's treatment of disabled people. So, the question is: Can we say that disability *itself* is what is causing the negative effects? Most people will emphatically say *yes* in response to this question, because disability causes one to lack certain goods that non-disabled people have (e.g., sight, hearing, the ability to walk, etc.). However, is it really the case that disabled people *merely lack* certain goods? If disabilities provide people with certain goods, then we couldn't say that having a disability automatically makes a person worse off than if they were not disabled. Disability rights activist Harriet McBryde Johnson writes:

> Are we "worse off"? I don't think so. Not in any meaningful sense. There are too many variables. For those of us with congenital conditions, disability shapes all we are. Those disabled later in life adapt. We take constraints that no one would choose and build *rich and satisfying lives* within them. We enjoy pleasures other people enjoy and *pleasures peculiarly our own*. We have something the world needs. (Johnson 2020)

Testimonies from disability activists have given us good reason to think that disability is not *merely lacking* certain goods, one can also *gain* certain goods in virtue of having a disability.

In order for supporters of the medical model to say that there is something about having a disability that produces negative effects even in the absence of ableism, they have to say that there's something *automatically* or *intrinsically* bad about having a disability.[56] In other words, a bad-difference view must hold that there is no mediating factor between the disability and the badness it produces (Barnes 2016). This may sound like a strong stance to some people. Some may think that it's more reasonable to say that disability is *correlated* with negative effects, even in the absence of ableism. However, this isn't a strong enough position, because if disability is merely correlated with negative effects, then one can't claim with certainty that it is the disability *itself* that's causing the negative effects. The bad-difference view must show that the disability itself causes negative effects.

2.2. Is Disability on the Whole a Bad Thing?

Many supporters of the social model of disability argue that all the bad effects of disabilities are socially mediated. They often make this argumentative move because they wrongly assume that if they want to claim that disability isn't a bad thing, they also must say that

[56] Barnes (2016) provides four different kinds of bad-difference views. For the purpose of this dissertation, when I use the term "bad-difference," this simply means that something (e.g., disability, fatness) is intrinsically or automatically bad.

in the absence of ableism, there would be no negative effects associated with these embodiments (Barnes 2016, 27; see also Thomas 1999; Crow 1996). The problem that often accompanies this approach is that theorists fail to address what impairments are or how they may affect someone in the absence of ableism and thus, leaves that aspect of disability open to a bad-difference view of disability (Barnes 2016). In other words, this approach simply redirects the questions we have about disability toward impairment – the question becomes, "Is *impairment* something that's (by itself or intrinsically) bad for you?" (Barnes 2016, 27, emphasis added).

Barnes argues that we don't have to say that in the absence of ableism, there would be no negative effects of disability just to make the claim that disability isn't a bad thing. She argues that these two claims come apart, and she illustrates this point by using the terms *local bad* and *local good* along with *global bad* and *global good*. Barnes builds on the idea that disability *itself* is not a bad thing and adds that disability is also not *on the whole* a bad thing. In other words, we can recognize that there may be some negative effects of disability while still claiming that it doesn't have a negative effect on a person's overall well-being.

A disability may have some feature that causes something *negative* to happen for some amount of time (i.e., a local bad), but a disability may also have some feature that causes something positive to happen for some amount of time (i.e., a local good). A disability may be "locally" bad or good in that it is limited to only a certain feature of the disability, or it is only relevant to a particular time. For example, there may be certain points in time when deafness is accompanied with some negative effect(s) (e.g., not being able to share a common language with certain people), but it can also be accompanied with some positive experiences that one only has *in virtue of* being Deaf (e.g., learning to sign as a first language, experiencing music through vibrations) (Barnes 2016; see also Bauman and Murray 2014).

Additionally, for some people a disability may have a negative overall effect on one's well-being (i.e., a global bad), while for someone else, the same disability may have a positive overall effect on one's well-being (i.e., a global good). In other words, the very same disability may be *on the whole* a bad thing for someone and *on the whole* a good thing for someone else. For example, Beethoven's deafness was devastating *for him* because as a composer and conductor with a love for music, it negatively affected his ability to pursue goals and interests that mattered *to him*.

2.3. Is Disability Bad Simpliciter?

Even if one said that being d/Deaf was on the whole a bad thing, like in the case of Beethoven, this would still not make deafness *bad simpliciter*. If we said that deafness is bad simpliciter, this would mean that being deaf is bad for all of those who are d/Deaf. Likewise, if we said deafness is *good simpliciter,* this would mean that being deaf is good for all those who are d/Deaf. The other alternative is saying that deafness is *neutral simpliciter* – that is, being deaf is not good for those who are d/Deaf nor is it bad for those who are d/Deaf (Barnes 2016, 86). The reason for this is because even though deafness for Beethoven was a bad thing, it wasn't deafness *itself* that caused the reduction in well-being. This is because determining whether being disabled is good or bad for a person doesn't simply rely on determining whether disability is good or bad simpliciter with respect to well-being (Barnes 2016). A large part of the equation should include things like the person's personality, their plans, values, hopes, and dreams. As Barnes explains, "Whether being Deaf reduces, enhances, or has little effect on your overall well-being – that is, whether being Deaf reduces, increases, or doesn't change the amount of goods you have – will depend on *what else it's combined with*" (Ibid., 112, emphasis added).

In sum, the value-neutral model allows room for a wide variety of different perspectives and experiences of being disabled – from the very positive to the very negative – while still maintaining that disability is neutral simpliciter. Because disability is largely (and wrongly) viewed as something that is always bad with respect to well-being, disability has been viewed as a different kind of social category – one distinct from other social categories like women, people of color, members of the LGBTQI+ community, etc. simply on the basis of this presumed supposed relationship between disability and well-being. However, according to the value-neutral model, disability need not be something that is a bad difference. Additionally, in the same way that disability can be accompanied with local bads/goods as well as global bads/goods, so are other social categories. For example, other features like sex and sexual orientation can also be accompanied with local bads/goods and global bads/goods. Being queer may be accompanied with local bads or is on the whole a bad thing for a person, but that still has no bearing on saying that queerness is bad simpliciter. That is, we don't say that being queer is bad for all queer people. We acknowledge that being queer is neutral simpliciter. Thus, given that disability is also neutral with respect to well-being, then disability isn't a unique social category.

3. A Value Neutral Model of *Fatness*?

A value-neutral model of fatness, like that of disability, appears compelling in that it would understand fatness in a way that would best promote fat liberation and can account for the wide variety of first-person testimonies and perspectives of people in larger bodies. Some of the points made in previous chapters (especially chapters 1 and 2) about the unclear connections between fatness and poor health, and the central role that social determinants of health play in the connection between fatness and poor health, support the idea that we cannot say definitively that fatness *itself* is a bad thing. Even in cases where fatness is considered a global bad, or on the whole a bad thing, for certain individuals, this does not give us reason to presume that fatness is bad simpliciter. This chapter will mostly rely on the testimonies of fat activists to demonstrate why we should not assume that fatness is (1) in itself or (2) on the whole, a bad thing. Moreover, I argue that when it is assumed that fatness is bad simpliciter, we run the risk of oppressing people in larger bodies, even those who may be considered "infinifat" (or embodiments that the medical establishment would disturbingly consider "morbidly obese").[57]

3.1. Fatness Itself is Not a Bad Thing

I've already explained why we should be skeptical about the link the medical model often draws between fatness and poor health. There are three reasons for thinking that we do not have enough evidence for thinking that fatness itself is a bad thing. One, the research that has been published linking fatness to decreased health simply demonstrates a *correlation* between the two factors, there is no causal relationship (Lavie 2014). As previously discussed, a bad-difference view cannot use correlation to ground the claim that fatness *itself* is a bad thing. Second, fat activists have ceaselessly argued that almost all of the disadvantages that come with being fat are the result of society not making accommodations for such bodies, not from fatness itself. And third, there is an abundance of evidence not just supporting the claims of fat activists but also demonstrating how things like poverty, racism, and gender identity can influence a person's weight. The various social determinants of body weight also complicate the causal connection that many people want to make between fatness and poor health.

[57] This is not to say that all people in larger bodies are happy being fat. However, it is consistent with the mere-difference view to say that most people in larger bodies are unhappy because of the oppression and bias they experience in a world that tells them it is not okay to be fat. The kinds of experiences that are relevant to my point are those where fatness itself causes a decrease in one's well-being.

The issue of causation in "obesity" research has been discussed in some detail (Oliver 2005; Bacon 2008; Lavie 2014; Campos et al. 2006). One problem in particular is when epidemiologists try to determine the number of deaths caused by "obesity" itself. Recall the Mokdad et al. (2000) study that found that as many as 400,000 excess deaths were attributable to fatness. I already discussed how this study, in an attempt to assess the mortality risk associated *with poor diet and physical inactivity*, computed the mortality risk associated *with fatness*, thereby assuming that only people in larger bodies die from poor diet and physical inactivity. Another problem that arises is that by presuming that all excess mortalities that occur among people in larger bodies occur because they make bad behavioral choices, the researchers also overlook other potential causes of death. It is commonly believed that being overweight or obese is associated with a host of diseases and illnesses (e.g., Type II Diabetes, high cholesterol, high blood pressure, cancer, etc.), however, the findings on this association are diverse and inconclusive (Lavie 2014).

In fact, the relationship between fatness and poor health – when it exists – can be understood as a version of the "old chick-and-egg scenario" because it's hard to know which came first: fatness or a related illness (Lavie 2014, 35). By assuming that fatness itself is what is associated with mortality, the researchers ignore the possibility of fatness being a symptom of something else happening in the body (e.g., a response to blood sugar imbalances, insulin resistance, and/or elevated blood pressure). For example, as Mokdad et al. (2004, 1243) say, "In this study we also did not examine the effects of high blood pressure and cholesterol or lipid profile on mortality, although some of the effects of these factors are mediated through poor diet and physical inactivity [i.e., through overweight and obesity]." In other words, given that the researchers conflate fatness with poor diet and physical inactivity, the researchers assume that being overweight or obese causes high blood pressure and cholesterol, which is something that has not been reliably demonstrated. They consciously decided not to consider the possibility that high blood pressure or high cholesterol (not *fatness itself*) contributed to their estimates on mortality.

In addition to the lack of scientific evidence for thinking that fatness itself is what causes illness and disease, we have to consider the ways in which other social factors contribute to poor health. Some fat activists have claimed to *genuinely love* their bodies as they are, but they struggle with that self-love when living in a society that tells them they should not love their

bodies (e.g., see West 2016; Tovar 2018). Other fat activists don't claim to love their bodies, but they also don't view them as a bad-difference.[58] This is because they recognize that the negative effects of being in a larger body come from *society*, not from their bodies. Virgie Tovar, for instance, explains that people can be happy in a body of any size, but it is our dominant culture (i.e., a fat phobic and diet-infused culture) that tells people in larger bodies that they are bad for having such bodies:

> The real problem is that we live in a country that promotes size-based bigotry, and yet we are told—and we believe—that the problem is that we are not healthy enough. The real problem is a culture that uses weight as a proxy for humanity and morality, and yet we are told—and we believe—that the problem is that we don't know how to eat correctly . . . The real problem is that our culture is maintained through a vitriolic matrix of sexism, racism, misogyny, transphobia, ableism, healthism, and classism that erodes the physical, spiritual, and mental health of all people; and yet we are told—and we believe—that the problem is that we aren't trying hard enough. (Tovar 2018, Kindle edition)

Tovar, and many other fat activists, are pushing back against society and its mentality surrounding the "obesity epidemic" – a mentality that asserts that people in larger bodies are not healthy and they are not trying hard enough to lose weight. Tovar is part of a growing vocal minority pushing back against societal standards and beliefs. It is misconceptions like these that contribute to the disadvantages and stigmas that people in larger bodies experience. This point is precisely one that Roxanne Gay makes in her book *Hunger*:

> Today, I am a fat woman. I don't think I am ugly. I don't hate myself in the way society would have me hate myself, but I do live in the world. I live in this body in this world, and I hate how the world all too often responds to this body. Intellectually, I recognize that *I am not the problem*. *This world and its unwillingness to accept and accommodate me are the problem* (Gay 2017, Kindle edition, emphasis added).

What these personal accounts suggest is that *most* of the suffering that people in larger bodies experience comes not from fatness itself, but from the way society perceives fatness and fat bodies.

[58] Some say that people shouldn't feel that they have to love their bodies to have a healthy relationship with them. This sets the bar pretty high and could make people feel worse for not being able to *love* their body. Rather, all people need to develop a better relationship with their bodies is a *neutral* attitude toward their body (e.g., see Kneeland 2023).

3.2. Fatness on the Whole is Not a Bad Thing

Even in cases when we have good reason to think that fatness itself causes certain negative effects, that does not mean that fatness is *on the whole* a bad thing. There are positive experiences that come with being fat, but a value-neutral model can also account for the different experiences of people in larger bodies that are contextually *bad*. For instance, some people are fat to the point where it can be difficult to walk short distances or to run at all. Roxanne Gay explains that she struggles in achieving contentment with her body despite knowing that we live in a toxic anti-fat culture that upholds unreasonable beauty standards. She feels uncomfortable in her body sometimes because "[n]early everything physical is difficult…More often than not, I am in some kind of physical pain" (Gay 2017). Merely walking for long periods of time causes her thighs, calves, feet, and lower back to ache and causes her to sweat profusely. As a result, Gay explains that she does not feel comfortable in her body and this discomfort is not "entirely about beauty standards" (Ibid.).

From the value-neutral view, these negative aspects of being extremely fat need not be ignored. This view can fully acknowledge Gay's experiences that some aspects of fatness are bad *for her* with respect to particular features of or particular times, but still uphold the view that extreme fatness itself is not a global bad because "something can be neutral overall, but [still] have aspects which are bad" (Barnes 2016, 76). For example, Gay also writes, "There are things I want to do with my body but cannot" – it is these types of desires that Gay has in combination with her fatness (which prevents her from fulfilling these desires) that make the fatness locally bad for her (Gay, Kindle edition). If spending time with her friends who want to "do impossible things like go to an amusement park or walk a mile up a hill to a stadium or go hiking to an overlook with a great view" is what Gay cares about doing, then her fatness will be a local bad in relation to *these types of situations* and *these types of desires* (Gay, Kindle edition). If Gay did not care about being physically active, then her inability to walk for long periods of time would not be a local bad for her.

3.3. Fatness is Not Bad Simpliciter

Even if Gay felt that being fat decreased her overall well-being, or in other words, considered it a global bad *for her* – we could still not claim that fatness is bad simpliciter. In a size-inclusive and accommodating world, there may still be people in larger bodies who are disadvantaged – not because of anti-fat sentiments but simply because their being fat presents

certain obstacles given their personal values, interests, dreams, and goals. These obstacles may be so severe that they decrease the person's overall well-being. However, it's not fatness on its own that causes the decrease in well-being – its fatness in combination with the person's interests and goals. Thus, even in these cases fatness alone is not causing the decrease in well-being.

Additionally, claiming that fat is bad simpliciter would deny all of the fat-positive first-person testimonies. It should not be assumed that there is no value in being fat, particularly when there are first-person testimonies that say otherwise. Countless Instagram accounts document the lives of people in larger bodies as they go about living their lives in the ways they deem most enjoyable and fulfilling. There are fat powerlifters,[59] trainers,[60] triathletes,[61] yogis,[62] dancers,[63] models,[64] singers and songwriters,[65] and actors and actresses[66] all of whom are successful in their own right and advocate for body acceptance and fat inclusivity.[67] In fact, it is their fatness that has made their achievements and experiences as joyful and exciting as they are.

Take, for example, Lizzo—a famous singer and songwriter whose song "Truth Hurts" took the number one slot on the Billboard Top 100 in 2019. Lizzo, who personally suffered from a lack of body positivity at a younger age, has learned to love her body exactly as it is. Lizzo has used her platform to preach body positivity because, as she says, "we [all] deserve to feel good

[59] For example, 2012 Olympian weightlifter Holley Mangold is only 5 feet 8 inches tall and weighs 350 pounds.
[60] For example, in Canada, a fitness company called Body Positive Fitness hires fat (although not exclusively) fitness instructors, e.g., Julie (@jewelzjourney) and Shannon (@fringeish), to encourage people of all body types to feel welcome in a space that's truly diverse. For more information, see the company's website: https://www.bodypositivefitness.ca (accessed April 4, 2020).
[61] For example, Ragen Chastain (@ragenchastain) is not only a fat activist but also a National Dance Champion, a two-time marathoner, and a triathlete. For more information about Ragen Chastain, see her blog: https://ironfatblog.wordpress.com/.
[62] For example, Jessamyn Stanley (@mynameisjessamyn), Shannon (@fringeish), and Tiffany Crociani (@tiffanycroww) are just a few examples of fat yoga instructors who advocate for body inclusive yoga.
[63] For example, blogger and radio show producer Whitney Thore – who grew up dancing and even taught dance – returned to dance when the radio show she produces called *Jared & Katie in the Morning* created a dance video called "A Fat Girl Dancing" on the radio show's YouTube channel. This video went viral and today has more than 10.5 million views. As a result, Whitney Thore was asked to talk on the Today Show, ABC News, and CNN. (Whitney Way Thore, "Original – A Fat Girl Dancing: Wiggle [Jason Derulo ft. Snoop Dogg]" streamed live on May 27, 2014, YouTube video, https://www.youtube.com/watch?v=Hj-VmZYcUhQ).
[64] For example, Tess Holliday, Hunter McGrady, Nzinga Imani, and Essie Golden.
[65] For example, Lizzo and Beth Ditto.
[66] For example, *Precious* star Gabourey Sidibe, and *Bridesmaids* and *Pitch Perfect* star Rebel Wilson.
[67] Some of the celebrities I listed here (e.g., Gabourey Sidibe and Rebel Wilson) among others (e.g., Jonah Hill) have gone through body transformations, but it is not clear whether they chose to do this because their fatness was the direct cause of their unhappiness or because they wanted the fat shaming and bullying they regularly experienced to stop – though, I think it's important to note that many of those who have transformed their bodies are actors.

as hell" regardless of body type (Kale 2019). Lizzo's Instagram has become a great reference for fat activism and for those in recovery from eating disorders. Lizzo has created a life full of great experiences *because* she is fat, as opposed to *in spite of* being fat. Her fatness made these experiences what they were—they were fulfilling because she is a fat woman preaching body positivity on a world-wide platform in her glamorous and revealing wardrobe and feeling good while doing it. Lizzo's message and experiences would not be the same if she were just another thin musician preaching body positivity.

Some people claim that being in a larger body has improved their psychological and emotional well-being. For instance, a college student named Nicole explains how she went from wearing a size 10 to a size 22 over her years as an undergraduate student. Despite what many would probably think, Nicole says that she finds herself speaking up more now that she's in a larger body. She says, "You could say that as I gained weight, I also gained a mouth, an attitude, and a spine" (Wann 1998, 63). In other words, some people – as Charlotte Cooper puts it – feel "blessed in [their] difference" despite sometimes feeling "isolated, lonely, ugly and unworthy" (Cooper 2019, 31). Nicole is appreciative of her fatness and the things it has allowed her to do and accomplish. Being fat has taught her to *accept* her body as it is, "dimples, stretch marks, cellulite, and everything" (Wann 1998, 36). She is grateful to her body for making her a better version of herself – a version of herself that exhibits self-respect, confidence, and greater self-esteem (Ibid.). Another activist writes: "It's very difficult to explain why I like being fat and how it makes me feel. Words like soft, warm, comfortable, earthy, and real all come to mind" (Ibid., 34). This is all to say that there are many cases in which people have experienced clear improvements in their attitudes, personalities, and overall well-being *in virtue of being fat*.

There are many testimonies like the ones just described from people in larger bodies expressing the joy, empowerment, and peace of mind that accompany their fatness. Given these types of fat-positive testimonies, in addition to not having enough justification in thinking that fatness *itself* is what causes the accompanying bad effects or in thinking that these bad effects seriously diminish one's overall level of well-being, we cannot say that fatness is bad simpliciter. While there may be some things about fatness that are bad for particular people and in particular contexts and some cases where fatness has a negative effect on overall well-being, there are also unique local goods that one can experience in virtue of being fat and fatness may have a positive

effect on the overall well-being of some individuals. Thus, we should interpret fatness as a mere-difference among bodies, not as a bad-difference.

4. Is Fatness a Disability?

To make my argument that the value-neutral model of disability should be used in the context of fatness, I have been drawing similarities between fatness and disability. The similarities and differences between fatness and disability have already been discussed to some extent (e.g., see Cooper 1997; Kirkland 2006; Herndon 2002; Mollow 2015) and some scholars have also made arguments in favor of merging fat studies with disability studies (e.g., see Mollow 2017). Determining whether fatness itself *should be* considered a disability is not something that I – a non-fat, non-disabled person – take lightly. I also don't think there is a clear answer to the question: "Is fatness a disability?"

The answer is complicated for several reasons. For one, it depends on how we define disability. If disability is just the disadvantages produced by social prejudice and lack of a welcoming built environment, then I would say that fatness is a disability.[68] Other disability definitions are less clear. Barnes (2016) says that her definition of disability "is closer to what is often meant by 'impairment' in the literature on disability" despite proposing a moderate social constructionism view of disability (5). She defines disability as "whatever the disability rights movement is promoting justice for" (Ibid., 43), and given this definition, it certainly isn't clear whether fatness is a disability. According to Barnes, this is a question that disability activists should answer for themselves.

Several philosophers of disability have objected to Barnes' constructionism given that the disability rights movement could be promoting justice for an overly restricted set of people (Wasserman 2018; Howard & Aas 2018; Lim 2018).[69] Still, on Barnes' view, the definition of disability can be somewhat dynamic. If justice is achieved for people with a particular bodily condition defined as a disability, then it will cease to be a disability; if other conditions become

[68] If supporters of the social model of disability do not think that people in larger bodies should be considered disabled, or at least those on the smaller side of the fat spectrum, it seems like the social model of disability would need modifying. Even those on the smaller side of the fat spectrum encounter disadvantages simply due to their bodily mode of functioning. For example, those who are considered "Mid-fat" (or US women's size 20-24 or 26, which is smaller than "Lane Bryant Fat") may not need assistance with walking, but they do encounter access issues with public spaces and seating.

[69] This is a very interesting concern that deserves attention, however, for the purpose of this dissertation, I will not be exploring this objection in much depth.

matters of concern for the disability rights movement, then they will enter the category of disability. Thus, even if disability activists are not currently fighting for fat justice, perhaps they could be urged to do so.

However, I find it interesting that many fat activists, despite listing numerous ways in which fat and disabled people have similar experiences, are nevertheless hesitant to call themselves disabled. Cooper says, "There is an uneasy sense that by appropriating the label 'disabled' fat people are invading and colonising the achievements of disabled people, forcing an all too familiar and uncaring disempowerment" (1997, 33). In other words, Cooper feels uncomfortable calling herself disabled because she feels as though she is establishing political control over a term that isn't hers to control. Like Barnes, Cooper also places a lot of emphasis on the role of "solidarity *judgments* about [the] types of factors that make something a disability, rather than the *factors* themselves" (Barnes 2018, 1156). However, the problem with this is that we still don't know what things solidarity judgments are tracking that would make them disability-related solidarity judgments (Barnes 2018).

This leads to a second concern I have about calling fatness a disability. I can imagine that there are many people in these respective social justice movements who would not want to merge the two social groups. For instance, there are very likely some people in larger bodies that would reject the label "disabled" because they understand disability through the medical model of disability (Cooper 1997). Because of the ways that the medical model conflates fatness and ill health, some people in larger bodies may be particularly keen to avoid linking fatness to disability, because they presume it would suggest ill health. Likewise, I also think that there are disabled people who would not want fatness to be considered a disability as a result of interpreting fatness through a medical model lens. Even though disability is a somewhat fluid identity category (i.e., one can acquire disability, some disabilities can be removed, and others are congenital), they might see disability as a matter of the body one has to work with, and view fatness as a matter of the body one chooses through behaviors (e.g., diet and exercise choices). Ableism and anti-fatness are pervasive and will likely influence the way people in these groups want to self-identify and who they want to identify with.

A third reason for thinking the question of whether fatness is a disability is difficult to answer is because fatness exists on a spectrum, as discussed in chapter 1. Like disability, there is much heterogeneity among larger bodies, and in some cases, fatness and disability are more

likely to overlap (e.g., those who are "Infinifat," or larger than a US women's size 32), however, in other cases, the two identities are less likely to overlap (e.g., those who are "Lane Bryant Fat," or US women's size 26 to 32). Of course, it's also possible for a person whose body is on the smaller end of the fat spectrum to also be a wheelchair user, have an intellectual disability, be d/Deaf, etc. In these cases, people in larger bodies are disabled in more than one way – they not only have problems accessing public spaces, seats, or clothing that fit their bodies, but they also have trouble accessing other things like stairs, or have an even more challenging time getting employed or receiving a quality education.

A fourth concern of mine is that even though I think fat and disabled people have far more in common than not, fatness and disability are slightly different in important ways. One way in which fat and disabled people have similar experiences is in that they are both medicalized and as a result, wrongly presumed to be damaged and in need of fixing, which may sometimes result in feelings of shame and self-loathing. While both kinds of embodiments are largely viewed as undesirable and members of both groups experience shame, the stigma associated with these groups differ to some degree – while disabled people are largely pitied, people in larger bodies are mostly blamed. The belief that peoples are individually responsible for their weight makes people in larger bodies less likely to be pitied. This is because to have pity for someone requires compassion, and if the belief is that people in larger bodies are choosing to be fat (e.g., out of laziness), then they don't deserve compassion or pity. This theoretical difference between the two identities has practical significance. As a result of this perceived difference, people are more understanding of accommodating disabilities, which typically occur outside a person's control, than fatness, which is thought to be brought on by the individual. People in larger bodies are often viewed as undeserving of accommodations and are thought to be taking advantage of government funding (Herndon 2002; see also Cook 2015).

This leads to another difference between the two groups. While it is largely and wrongly presumed that fatness is something that can be controlled (see chapter 2), this kind of embodiment can change in a way that most disabled bodies can't. Our body weight changes constantly – it changes not just from month to month or from week to week but even from hour to hour. Some disabled bodies may fluctuate in some sense – e.g., people with chronic illnesses may have "flare-ups" – but this doesn't make the body any less disabled. Though there are problems with saying this, bodies can oscillate between fat and non-fat categories in a way that

bodies can't oscillate between disabled and non-disabled categories. This is one reason why people feel justified in thinking people in larger bodies are blameworthy and undeserving of accommodations.

Despite the fact that fatness is mutable in a way that much disability is not, the two groups are similar in that members of these groups are often subject to unsuccessful yet invasive treatments or attempted cures (Herndon 2002). For example, to "cure" deafness, cochlear implants are often chosen by hearing parents for their d/Deaf children; however, there is much controversy surrounding this decision. It is popular for parents to post emotional videos on YouTube showing the reaction of children hearing their parents' voice for the first time, and parents have received a lot of criticism for doing this:

> The most erroneous message the videos propagate is that cochlear implants *fully transform* deaf individuals into hearing ones. With present technology cochlear implants are a tool, *not a cure*. The most successful cochlear surgeries *never restore full, natural hearing*. Many recipients struggle to distinguish sounds, particularly in environments with a lot of background noise. The comments on many of these videos embrace the fallacy that cochlear implants are a *one-size-fits-all solution*. (Cooper 2019, 470, emphasis added)

Similar to the way in which cochlear implants don't cure deafness, bariatric surgery doesn't cure fatness. As mentioned in chapter 2, bariatric surgery is an invasive intervention that often has many negative side effects even when "successful" (Heymsfield and Wadden 2017; Berg 1999; Bacon and Aphramor 2011).

In a dissertation focused on fat oppression, it is not necessary to determine whether fatness is a disability. It's enough to demonstrate that there are a lot of similarities between the two groups. I believe that determining whether fatness should be considered a disability requires a more thorough understanding of the history of disability and the disability rights movement, and a robust exploration of ableism. However, I will say that despite the important differences between disability and fatness and my stance on whether fatness should be considered a disability, I nevertheless think it would be beneficial for both groups to forge a single united community in solidarity to resist their oppression.

5. Objection: An Adaptive Preference for Fatness?

In response to the argument that we ought to take the first-person testimonies about the lived experiences of being fat more seriously, one might object on the basis of *adaptive preference*. In other words, one might argue that people in larger bodies only say they enjoy being fat or find value in fatness because they have altered their preferences to cope with being fat, or with living in a sub-optimal body.[70] In this section, I will briefly explain the origins of the adaptive preference argument and how it has been applied to disability, to consider whether a similar objection might be made in relation to fatness.

The adaptive preference argument, developed within rational choice theory (Elster 1983), has received significant attention in relation to the capabilities approach (Nussbaum 2000; Sen 1999), which theorizes that the freedom to achieve well-being is a primary human good, and that well-being is linked to having certain necessary goods or capabilities. Human flourishing, in other words, requires certain capabilities. People who do not have those capabilities might subjectively report being happy with their situation, but objectively speaking, limitations on their capabilities demonstrate an injustice or a tragedy. Their adaptive preferences – preferences lowered in response to limited viable options – then, can stand in the way of justice.

Adaptive preferences tend to form in oppressive situations, and typically, oppressed people can recognize the constraints on their freedom and will report their unhappiness with their situation. However, in some oppressive situations, people may adapt their preferences given the oppressive situation, and report being happy, even with their limited options. For instance, it could be argued that a battered woman who values her abusive relationship may have lowered her preferences in such a way that she comes to value this relationship as a result of having limited viable options available to her – that is, she may adapt her preferences to suit her situation (Barnes 2009, 2; see also Elster 1983; Nussbaum 2000).

Feminist philosophers have explored this topic because it raises important questions about whether people in oppressive situations can *autonomously* choose to continue living in oppressed situations. In contrast, rational choice theorists are interested in adaptive preferences because it complicates the question of whether people who choose to continue living in

[70] This argument has already been made in response to fat activism. For example, just consider conservative commentator Candace Owen's response to fat activism. She described the movement on Twitter as "fashionable stupidity [that] needs to stop" (Owens 2020). In a response to a comment made on her post, she further explained how this movement should be "shamed" because "it's unhealthy and wrong" (Ibid.). Owens would clearly argue that the fat acceptance movement is an adaptive preference.

oppressive or suboptimal conditions are acting *rationally*. Both approaches recognize that there are two central features of adaptive preferences: 1) the preferences must be changed or formed due to a constraint in options; and 2) the preference must be sub-optimal. In other words, if one is said to have an adaptive preference, then she is altering her preferences toward something sub-optimal due to limited options.

However, in order to determine if someone has an adaptive preference, we must determine whether the preference is actually *sub-optimal*. Thus, when certain bioethicists have argued that disabled people who claim to value their disability have an adaptive preference, disability scholars have claimed that this argument relies on a major assumption and circular reasoning. The critical point of this objection "seems to be whether we can get warrant for thinking—without begging the question or over-generalizing—that disability is something bad or sub-optimal toward which merely person-affecting preferences have been directed" (2009, 21). Barnes argues that the adaptive preference argument falls prey to begging the question because those who make this argument are objecting to the first-person testimonies of disabled people merely because they assume that being disabled is a sub-optimal way of living – but this is precisely the question that is up for debate. To make the adaptive preference argument work, able bodied people "take their own first-person experiences as evidence for their position," but this is just another way of saying that non-disabled people are in a better position to evaluate the well-being of disabled people (Barnes 2016, 133).

This situation constitutes a *testimonial injustice* (Fricker 2007). The testimonies of disabled people about their own experience are discounted because of a presumption that they cannot fully appreciate what it is like to be non-disabled or know what is good for them, but non-disabled people's assumptions about their own bodily states are treated as self-evident. While some disabled people might not know what it is like to be non-disabled, non-disabled people also don't know what it is like to be disabled. Why should we assume that non-disabled peoples' judgements about the quality of life of disabled people are better or more accurate than the first-person testimonies of disabled people (Amundson 2005)? Barnes further argues that the adaptive preference argument falls prey to over-generalization in that if we use this argument to argue that disabled people merely have adaptive preferences, what stops others from saying that, for example, being gay is also just an adaptive preference (i.e., gay people say they prefer being gay,

but it is a suboptimal state, and they have lowered their expectations based on the particular bodies they inhabit).

I imagine that a similar objection could be made in response to the value-neutral model of fatness. One may claim that people in larger bodies clearly have a lower quality of life than their non-fat counterparts, and therefore, being fat should not be valued or preferred over not being fat – that is, a preference for being fat is clearly a preference for a suboptimal state. Our reasons for thinking that there is no value in being fat, however, derive from the medical model – it is believed that being fat would increase one's odds of developing other illnesses (e.g., diabetes, high blood pressure) and are more likely to die prematurely.[71] However, as I've already demonstrated, we don't have good reason to think that fatness itself is the problem nor do we have good reason to think that no value can come from being fat. There are many first-person testimonies of fat activists claiming that they value their fatness or enjoy being fat, and that objective goods accompany their experience in virtue of them being fat. These testimonies, however, get berated for "glamorizing obesity" and "promoting unhealthy lifestyles" and suppressing these testimonies is justified because it is bad to be fat.

To make the adaptive preference argument successful, we must consider the evidence we have for thinking a particular way of living is suboptimal. Recall that Barnes argues disability is not a unique social category because its relationship to well-being is very similar to the relationship that other social categories (e.g., women, people of color, members of the LGBTQI+ community, etc.) have to well-being. This is why Barnes argues that those who disagree with her view have to provide some other kind of "independent evidence" (i.e., evidence that does not merely rely on the testimonies of the non-disabled or disabled) for thinking that disability is sub-optimal. As Barnes argues, disability is only suboptimal to certain individuals if it prevents them from doing things that they really care about. Disability is not suboptimal to everyone who is disabled.

[71] One might argue that if a person died as a direct result of their fatness, it could be argued that, in this case, being fat would be a bad-difference. However, Barnes addresses this issue by saying that if you want to draw a connection between a shortened lifespan and the bad-difference view, then it seems that any random thing that contributes to a shortened lifespan will also be considered bad-difference. For example, because males have a shorter life expectancy than females, it seems that this would suggest that there might be a bad-difference theory of maleness. This shows that there are many arbitrary things we don't consider bad-difference that contribute to a shortened lifespan (Barnes 2006).

Chapter 2 explained how the relationship between fatness and ill health is far more complicated than many presume, and all we can say is that there is a *correlational* relationship between the two. Additionally, given that research has shown that social determinants of health (e.g., weight stigma) can affect weight and health, this correlational effect cannot prove that fatness itself is what is causing a decrease in well-being. For this reason, we should also understand fatness as another social category that has no uniquely close relationship to well-being. There needs to be better evidence to prove that fatness is a bad-difference. If fatness isn't a bad-difference, then we have no basis for thinking that fat activists who claim to value their fatness are delusional or irrational, especially since we don't say this in response to members of other social groups who have pride in their identity. So, the question is, what gives us warrant for explaining away the first-person testimony in the case of fatness, but not in the case of other social identities like gayness? "The burden of proof is on the person who wants to say that valuing disability [or fatness] is *unlike* valuing gayness" (2016, 97). A testimonial injustice arises when it is presumed that people in larger bodies who say they value their fatness have adaptive preferences.

While fatness itself does not make living in a larger body a suboptimal preference, the oppression that accompanies larger bodies does make living in that kind of embodiment suboptimal. So, people in larger bodies who choose to forego dieting to lose weight are choosing a suboptimal way of living in the world. However, the alternative is also suboptimal: they can keep trying to lose weight. They may succeed, but chances are that they will not – it may actually make their life go worse for them – for example, they may engage in yo-yo dieting, develop an unhealthy relationship with food and their body, develop even more shame from not being able to lose weight, etc. Therefore, it appears that choosing to lose weight due to oppressive body/beauty norms may be the worse option of the two. Whatever choice a person makes, it is made autonomously given the information that they have at the moment and their exposure to oppressive conditions.

Even though choosing to forego dieting to lose weight is a suboptimal choice, it is still not an adaptive preference because even if conditions improved (fat oppression became less of a problem), these individuals would still make this choice. Some feminist philosophers (e.g., Khader 2011) have argued that oppressed people can autonomously choose certain adaptive preferences, and I agree. My view on adaptive preferences aligns with that of Serene Khader.

Khader offers a weak perfectionist conception of adaptive preferences, and under this view, adaptive preferences are autonomously made preferences that are incompatible with an agent's basic wellbeing that formed under unjust conditions and that an agent would reverse upon exposure to better conditions or the relevant (moral or nonmoral) facts.

Given this definition of adaptive preferences, I don't believe fat activists have adaptive preferences, *but I do believe people who choose to lose weight do have adaptive preferences*. Many of people who choose to diet or exercise more in order to lose weight oftentimes are people who are not as well versed in fat oppression and fat activism. However, even those who are well versed in these topics (e.g., Roxane Gay – see Gay 2018)[72] are making adaptive preferences because under improved conditions, many of them would not choose to undergo weight-loss surgery, go on diets, exercise more, or take weight-loss medication simply in order to lose weight.

Given the amount of pride people in larger bodies have *in virtue of* being fat, and the clear (and problematic) assumptions society makes about the well-being of people in larger bodies and the value of being fat, I believe we have good reason to question the dominant perspective of fatness and people in larger bodies. Moreover, the testimonies of people in larger bodies make it clear that when they do feel unhappy with their bodies, it is often a direct result of living in an oppressive society. There are social and structural injustices that are perpetuating and reinforcing fatphobia that our society does not scrutinize or challenge, and I argue that they stem from the overly narrow and medicalized perspective of fatness. Most people, however, still find it disconcerting to challenge the medical perspective of fatness, thereby perpetuating the injustice. My point is that by taking the vantage point of the medical model, we unjustifiably ignore the testimonies of fat activists and distort the central political goal of the fat acceptance movement. They are not "glamorizing obesity" or "encouraging unhealthy lifestyles" – they are demanding *justice*.

[72] Roxane Gay is an example of a fat activist who, despite undergoing weight-loss surgery, *did not* have an adaptive preference to lose weight. She may have made the decision to get surgery even if we lived in a fat accepting world. This is because her feelings about her body were not solely a result of fat oppression (Gay 2017).

6. Conclusion: The Value-Neutral Model as a Step Toward Fat Liberation

In this chapter I proposed a new model of fatness. In contrast to the widely held medical model of fatness, I have proposed a value-neutral model of fatness. The value-neutral model of fatness understands fatness as something that is neutral with respect to well-being. I argued that we cannot say that fat is bad simpliciter by demonstrating that we are not justified in assuming that fatness is always in itself or on the whole a bad thing. Given this, in addition to the fact that there are fat-positive first-person testimonies, it is best to interpret fatness as something that is a neutral mere-difference among bodies.

In the next and final chapter, I will describe the practical application of the value-neutral model of fatness and provide some potential forms of resistance to fat oppression. These forms of resistance are not sufficient for ending fat oppression, but they can help us make progress towards fat liberation.

Chapter 5: Where Do We Go from Here? The Beginnings of a Cultural Revolution

Against a background of deeply entrenched fat oppression that operates as a kind of cultural imperialism, what are the available avenues for resistance and change? In this chapter, I expand on Young's solution to cultural imperialism – i.e., a cultural revolution – and explain how it would apply to the case of fat oppression. A cultural revolution requires that we change cultural habits themselves, which requires both structural and individual level shifts. Cultures will not change unless "individuals become aware of and change their individual habits" (1990, 152). Given that those habits and beliefs are deeply ingrained and appear "normal" within our democratic society, the cultural revolution will require consciousness raising, and the willingness of individuals to make the *social choice* to work toward that change (Young 1990). For people to make this social choice, society must be made aware of the ways in which social meanings, tools, scripts, and assumptions contribute to injustice.

How might we begin revolutionizing the way we think about fatness? To help society become aware of the ways in which the dominant narrative of fatness infiltrates various aspects of our lives, we need to make space for and engage in activism in different spheres of social life. We will need to engage in and criticize the social practices that further entrench the medical model, offer an alternative model (i.e., the value-neutral model of fatness), and construct new tools of thought and action to create a more just society. This work can be done through (1) forms of activism by fat activists, including the demonstrative (e.g., rallies, marches, strikes, etc.) and literary (e.g., op-eds, books) ; (2) critiquing biomedical research and practice and producing research that uses other research methodologies (i.e., those found in participatory research); (3) the work of fat justice scholarship; and (4) robust educational reforms, both for the professional education of future and current health care providers and in K-12 education.

1. Fat Pride & Epistemic Justice

To challenge the dominant narrative of fatness, people in larger bodies must politicize the dominant culture – or in other words, "politicize habits, feelings, and expressions of fantasy and desire" – by "confronting the cultural imperialism that has denigrated or silenced" them (Young 1990 153-154). Politicizing our culture will require that members of the oppressed group speak

up about the ways they are oppressed and offer first-person testimonies, particularly those that express *pride* in their social identity.[73]

From the 1960s onward, fat activists have been working to politicize their identity and combat the "concern for health" objection to their movement. While there is some evidence that they are finally being heard, their message often gets appropriated by others to promote the interests of straight-sized individuals (e.g., with the body positivity movement) or gets distorted by an unsympathetic audience that makes their message sound absurd (e.g., when they are accused of "glorifying obesity" or "promoting unhealthy lifestyles"). This constant struggle can be exhausting and demoralizing. As emotionally taxing as it is, fat activists need to continue raising their voices and providing counternarratives that directly challenge the overly medicalized and pathologized perspective of fatness.

Speaking out about the experience of living in a larger body is a necessary part of creatin a cultural revolution. A lot of good can come from people in larger bodies educating others on the ways they are oppressed. This information can shed light on the ways in which our network of social meanings, tools, scripts, assumptions, models, etc., are producing unjust social practices. This draws attention to moral problems with our dominant conception of fatness, but it also highlights the ways in which it employs epistemically irresponsible "practices of reflection and internal critique" (164). For example, the epistemic shortcomings of the concern for health objection to fat acceptance has been called out by many fat activists for many years (see, for example, West [2016]; Cooper [2016]; Cottom [2019]; Baker [2015]; Gordon [2020]; Gay [2017]; Tovar [2018] for more contemporary pieces that have made this point). Continuing to interrogate the social practices in medical research and practice that are tied up in the medical model would help the movement gain some more traction.

The central aim of fat activism is to encourage public discourse about how it feels to be fat in our world, the complex experiences of fat people, and how fatness ought to be perceived. Fat activism encourages the diverse opinions and perspectives of fat people from all backgrounds and walks of life to "enable fat people to develop a realistic awareness of fat rights issues" (Cooper 1998, 173). The more fat people share their experiences and perspectives, the better we understand the complexity of fat rights issues, and the more power their message will have.

[73] It is important to point out how this puts the onus on oppressed individuals. However, a cultural revolution will also require that the more privileged *listen* to the testimonies of the oppressed and *do the work* of researching the ways in which people in larger bodies are oppressed and recognizing and interrogating their own biases.

Living in a society that clings to anti-fat biases, stereotypes, and assumptions, even fat activists aren't always happy being fat, as discussed in the previous chapter. A diverse range of perspectives from a diverse population will be important in providing an accurate account of the complexities of fatness (which I believe will provide evidence for a value-neutral model of fatness). Not all testimonies need to be positive to be beneficial for the social movement – they can be neutral and even be negative. Some people in larger bodies are seriously struggling with their body image and want to change their bodies because of how they're treated, some simply don't want their bodies to be stereotyped and discriminated against, some want to reclaim the word "fat" to describe a neutral feature of the body, others want to flaunt their bodies and show pride in their bodies – all of these testimonies matter and provide us with valuable information about the lived experience.[74] These diverse first-person testimonies demand "that norms and stereotypes about them be better informed by their own [varied] experiences" and by doing so, fat people are "demanding epistemic justice" (Barnes 2016, 183).

The more radically positive perspectives of fatness will be particularly helpful in making people realize that the medical model of fatness is wrong. While fat-neutral testimonies can be helpful in reframing the dominant narrative, fat-positive testimonies will be even more powerful, in that they: *celebrate* fatness, demonstrate a *deep appreciation* for fatness, show how to have a *fulfilling life* in virtue of being fat, and express *genuine pleasure* in fatness. These positive testimonies – built on pride – will seriously call into question the dominant narrative and compel us to "radically recast it in a way that shows that its normative assumptions are mistaken" (Barnes Ibid., 181).

In addition to sharing details about their lived experience and delineating the many ways in which they are oppressed, fat activists need to promote an alternative way of viewing fatness to replace the old (Haslanger 2017). We cannot simply throw out the dominant set of social meanings surrounding fatness – we have to replace it with a different set of social meanings. It's clear that fat activists want to be able to live unapologetically in their fat bodies, but more can be done in explaining how something like a value-neutral model of fatness would be in everyone's

[74] Fat pride is similar to the kinds of pride expressed by other marginalized social groups – e.g., disability pride, Black pride, LGBTQI+ pride. Pride movements have involved, for example, reclaiming of terms (e.g., disabled people reclaiming the word "crip", the LGBTQI+ community reclaiming the term "queer") and involves active celebration of one's identity (e.g., consider the slogan "Black is beautiful"). Similarly, fat pride has been involved in reclaiming the term "fat" and in promoting the image of happy fat people unapologetically flaunting their rolls of fat, cellulite, dimples, and stretch marks in glamorous and revealing wardrobes.

best interest. Fat activists should work on cultivating a new clear set of social meanings surrounding fatness and demonstrate why this is a better alternative.

However, there is only so much that fat activists can do. Fat activists have been pushing back against the dominant narrative for over 50 years, and their testimonies continue to be ignored or misconstrued. We cannot overburden fat activists with the responsibility to thoroughly teach everyone about the harms of fat oppression and the problems with the medical model. Other people have an epistemic responsibility to acknowledge and engage with the epistemic resistance that fat activists are participating in. This doesn't mean people should take everything fat activists as truth, but that they should, for example, (1) become aware of the assumptions they make; (2) learn to cultivate epistemic humility, curiosity/diligence, and open-mindedness; and (3) take responsibility for their attitudes, dispositions, and sensibilities (Medina 2013). In other words, in addition to being open to hearing the perspectives of others, particularly those perspectives belonging to marginalized individuals, people should learn to cultivate epistemic virtues. Developing fat pride is a social process.

2. The Epistemic Fruitfulness of Participatory Research

> I'm not actually particularly that interested in [health] and God I hate science…but I recognized very early on that if [fat activists] are ever to succeed, we have to get a foothold in the medical world and make them understand. And that's what I've tried to do because, when it comes down to it, the last argument is, 'oh but it's so unhealthy for you…' People get to discriminate against us because they're just trying to help us with our health.
>
> – Lynn McAfee[75]

In chapter 2, I argued that obesity researchers have made problematic choices based on illegitimate values informed by the medical model. These choices were not made in the interest of people's health; they were made in ways that further entrenched the assumptions in the medical model. Because "obesity research" has perpetuated an overly medicalized and pathologized view of fatness at the expense of well-being of people in larger bodies, this research has lost the trust of many people – for example, fat justice scholars as well as various kinds of

[75] See Shanewood (1999).

healthcare providers, researchers, therapists, and dietitians who support a weight inclusive and intuitive eating approach to health. Many people in larger bodies feel distrustful of medical research and health care practitioners (Phelan et al. 2015; Alberga et al. 2019). The distrust has transpired because researchers have failed to promote democratically endorsed aims by failing to acknowledge or take seriously dissenting voices, which predominantly come from fat activists. Given the political stance that fat activists take, and their disapproval of the way medicine has pathologized their political identity and has been used to justify their oppression, many fat activists want nothing to do with "obesity research."

Creating a cultural revolution for fatness, though, requires changing medical research practices. The best way to promote stakeholders' values and foster a more trusting relationship is through participatory research (PR) (Vaughn and Jacquez 2020). There are many different types of PR approaches that can be pursued depending on the research topic. "Obesity research" could benefit from utilizing various PR approaches such as community-based participatory research (Leung, Yen, and Minkler 2004), popular epidemiology (Brown 1992), participatory health research (ICPHR 2013), and emancipatory research (Zarb 1992). The main takeaway from these approaches is that for research to achieve its social aims, open dialogue and collaboration between researchers and stakeholders is needed throughout the research process.

Though collaboration exists throughout the research process, there are still questions of to what degree and how stakeholders will be involved. The answer to these questions depends on the PR approach that is chosen. The role of stakeholders in PR methodologies can range anywhere from simply providing qualitative data to researchers about their lived experiences to controlling the research project.[76] Stakeholders can be involved in identifying research questions, collecting data, data analyses, and the application of the findings. Involving stakeholders in these processes has shown to be helpful for researchers by, for example, identifying faulty data collection methods and identifying different – and perhaps more illuminating – ways of interpreting the data (e.g., see Brown 1992; Leung, Yen, and Minkler 2004). Some of these PR approaches require significant time and investment, particularly for building relationships

[76] French and Swain (1997), for instance, understand the aim of participatory research to be exploring and disseminating the views, feelings and experiences of research participants and ensuring that researchers are "accountable to" the participants (27). In contrast, emancipatory research aims "to change social relations of research production" in such a way that participants are in control of decision-making processes that shape their lives (28).

between communities and researchers, and may be considered too demanding of researchers given their academic contexts and pressures, but they nonetheless raise important questions about the kinds of values researchers should prioritize.

Much epidemiology research on obesity has sought to answer research questions with generalizable findings; however, because the data are often not diverse enough (and in many cases, purposely so), they cannot be generalizable in socially significant or pragmatic ways. Moreover, given the ways in which social determinants of health affect health and weight, much "obesity research" fails to account for these factors because disease can be more easily attributed to individual lifestyles devoid of social context. However, even social epidemiological research, which is specifically designed to understand the social production of health and illness, has often failed translate the research into action because it is inaccessible and irrelevant to the communities being studied (Petteway et al. 2019; Leung, Yen, & Minkler 2004; Smylie et al. 2012). In response to this shortcoming, some researchers have opted for what is called *popular epidemiology* (also called A People's Social Epidemiology – see Petteway et al. 2019). Popular epidemiology is distinct from other kinds of epidemiology in that it is returning to "the roots of epidemiological inquiry by recognizing social factors as part of the disease causal chain *through a participatory process*" (Leung, Yen, & Minkler 2004, 502, emphasis added). If traditional epidemiology was losing sight of its value to promote public health, the best way to remedy the situation is to learn from, empower, and build relationships with the participants.

Popular epidemiologists are less interested in generalizable information and more interested in generating knowledge that is most beneficial to the participants they are researching. Of course, for the information to be most beneficial for the participants, researchers must explore research questions that are at least in part determined by the participants themselves. Accessible and useful data also must be disseminated into the community to ensure that timely and relevant social action can take place and that researchers do not disproportionately benefit from the products of the research. The potential benefits of involving stakeholders, however, will be curbed if the values, interests, and perspectives of certain members of a group are ignored.

Thus, a more fundamental question regarding the implementation of PR methodologies in "obesity research" is, which members of the stakeholder community should be involved? If certain members of the stakeholder community are excluded, the research may still run the risk

of impeding democratically endorsed aims. For example, recall that in chapter 3, I mentioned how there have been some recent attempts to incorporate "patients living with obesity" in research and dissemination (e.g., the European Coalition of People Living With Obesity).[77] While this is certainly a step in the right direction – because the voices of stakeholders are potentially having some impact on "obesity research" – the problem is that these groups do not represent a diverse set of experiences and perspectives on what it is like to live in a larger body. Instead, they consist of bariatric patients who appear to endorse the medical model given that their primary job is to educate people who live with and are affected by obesity and their campaigns are often heavily sponsored by weight-loss and pharmaceutical companies (ECPO, n.d.).[78] It is not enough to include people in larger bodies who have similar interests and values. For a scientific community to reap the epistemic benefits that come from participatory and emancipatory research, the community must engage in critical reflection and scrutiny to ensure that the research methods and background assumptions are justified and promote democratically endorsed aims. The experience and perspectives of fat activists give them the ability to notice and challenge presumptions, consider a larger range of hypotheses and explanations, and consider new areas of inquiry (Wylie 2003; see also Douglas 2005 and Intemann 2015).

In addition to incorporating stakeholders, "obesity research" could also be improved by taking a more interdisciplinary approach. For instance, the inclusion of critical humanists in research teams could help shift the kinds of questions asked, the concepts used, and the interpretations of data made (Reardon et al. 2023). These research teams could include fat justice scholars and bioethicists who have already published work on the harms of weight stigma and current public health approaches to obesity (e.g., see contributors in Pausé and Taylor 2021). Like feminist scholars who have pushed back against mainstream research models, studies, and findings designed by and based on men, "fat studies scholars [have] shown that the experiences of fat individuals do not mirror what studies in dominant obesity paradigms suggest they should be" (Brown 2016).

Though most people generally accept that weight discrimination and fat-shaming are wrong, the idea that people in larger bodies can live enjoyable and fulfilling lives more directly

[77] See https://eurobesity.org; I thank an anonymous reviewer for mentioning this example and encouraging me to elaborate on it.
[78] See https://eurobesity.org/about/partners/

challenges the bias in favor of the medical model.[79] The inclusion of fat activists in research may sound like something that could jeopardize the integrity of science –because it politicizes science, or because it removes the ideal of impartiality – they are simply stakeholders that, unlike many bariatric patients, have pride in their fat embodiment.[80] Utilizing PR methodologies would help incorporate marginalized voices, which in turn, is likely to produce a more "vigorous and epistemically effective critical discourse" (Longino 2002, 131). If the inclusion of such perspectives is achieved, a scientific community that reaches a consensus does so not as a result of economic or political power nor through the exclusion of other perspectives but rather, as "a result of critical dialogue in which all relevant perspectives are represented" and exposed to the broadest range of criticism (Ibid.). While there is more work to be done in ironing out details as to how to involve fat activists in "obesity research," and in ways that preserve the epistemic integrity of scientific research, this helps to reduce the influence of the medical model. I do not believe that stakeholders' involvement in research and the promotion of interdisciplinary research will alone dismantle the medical model, but it plays an important role in challenging the self-proclaimed aims of obesity researchers. Truly embracing democratically endorsed aims will allow obesity researchers to discover a wider range of research questions, evidence, and possibilities.

3. The Role of Education in Dislodging the Medical Model

Formal education plays an essential role in maintaining fat oppression and can be altered to help create a cultural revolution. For example, classes, training workshops, and continuing education can work to explain how fat oppression manifests in society and how it is being reproduced, help students identify their own implicit or explicit biases and assumptions, and encourage students to become critical thinkers. Because courses like Fat Studies and Critical Weight Studies – i.e., courses that "problematize 'obesity'" (Cameron and Russell 2016, xiv) – offer a novel approach to understanding fatness, they are a key mode of helping to remake

[79] In other words, obesity researchers have taken for granted something that fat activists think is far from obvious (Koskinen, forthcoming). This is very similar to the ways disability activists have directly challenged the dominant personal tragedy model of disability and impairment by expressing pride in their embodiment (Swain and French 2000).

[80] Some may think incorporating fat activists is problematic because it has been wrongly argued that fat activists are encouraging unhealthy lifestyles and glorifying obesity. This is not the message of the fat activist movement. Other pride movements have not been about encouraging people to adopt their lifestyles. For example, the purpose of the LGBTQI+ movement is not to encourage people to be gay. Rather, the purpose of pride movements is to celebrate a marginalized identity in the face of societal stigma.

cultural norms. They will be particularly important for future and current health care providers and children.

3.1. The Education of Health Care Providers

To prevent "obesity research" from continuing to enact harm on people in larger bodies, we need to ensure that future members of the medical community (e.g., health care providers, researchers, scientists, public health policy makers, etc.) are aware of how pervasive and harmful anti-fat biases and assumptions are. Transforming the way fatness is talked about in medicine will also help to shift how it is viewed in the general public. To do this, we need to educate future health care providers in medical schools on how to appropriately understand fatness (e.g., its complicated etiology and how it affects the body), how anti-fat bias negatively affects the health and well-being of people in larger bodies, and how they should treat their patients in larger bodies. This will improve the medical care patients receive and will produce better public health policies that don't simply target individual behavior. Future health care providers will have a lot of influence in the way fatness will be perceived in the coming years.

In college, courses in nutrition, kinesiology, epidemiology, dietetics, exercise physiology, public health, clinical medicine, etc., should generally discuss how and why marginalized identities are often neglected in these areas of research and practice, and how this exacerbates the injustice they already experience. Consider how many such courses now address issues of race and gender and, increasingly, disability. Including attention to fatness as an identity would be an opportunity to more specifically explain how people in larger bodies are harmed by biases and assumptions about fatness and the behaviors, habits, or lifestyle choices that cause it. Educators could go through case studies that demonstrate how patients could get misdiagnosed or go undiagnosed simply because of their size or how certain research methodologies or statistical methods can misconstrue the data.

Also, courses in liberal arts departments on women's and gender studies, disability studies, and queer studies should incorporate discussions on fat oppression. There are important and relevant details about fat oppression and fat activism that I think would be of interest to scholars and educators in these areas of study. For example: (1) fat activism was spearheaded by and is still heavily composed of members of the LGBTQI+ community, (2) fat activism was influenced by second wave feminism, (3) fat oppression disproportionately affects women, and (4) there are many undeniable overlapping values and experiences between people in larger

bodies and disabled people. The ways in which the topics of fat oppression and fat activism overlap with topics in women's and gender studies, disability studies, and queer studies are interesting and worth exploring.

3.2. The Education of Future Generations

Not only is it important to teach this information in medical schools and college, but also in K-12 education, particularly since children begin internalizing anti-fat sentiments very early on in their lives (Brody 2017). To help prevent children from learning anti-fat biases and stereotypes or at the very least encourage them to critically reflect on these biases and stereotypes, several things that can be done at the level of K-12 education.

Health education classes are an opportune time to challenge children's predominant views of fatness. However, health and sport classes frequently do the opposite – they perpetuate and further entrench anti-fat biases and stereotypes and reinforce the idea that only certain kinds of bodies are acceptable. In health classes, children often learn the "calories in, calories out" equation for fat loss/gain. They learn that their size is caused by the things they eat and how much they exercise, so it's no surprise that health and exercise courses focus on "educating children to make the 'correct' choices for health, lifestyles, eating, exercise, and, of course, fat avoidance" (Pringle and Powell 2016, 126).

Health and exercise courses can be shifted from emphasizing relationships between food, exercise and weight, to educating children on how the body responds to various nutrients in food and the biological processes that happen in the body in neutral terms. These courses should also educate children on the social determinants of health so that they learn early on that health cannot be reduced to one's individual choices.

Educators themselves need to be made aware of the ways in which they contribute to harmful messages about fatness. It has been shown that a large percentage of school faculty and staff hold strong anti-fat biases and stereotypes (Puhl and Latner 2007). Educators should take workshops on anti-fat bias to learn about microaggressions related to fatness, and to develop potential strategies for addressing fat bullying in school. These kinds of workshops should not just be taken by teachers but should also receive the support of other community members including coaches, school nurses, and even parents. It is important for all of the adults who are a part of a child's education to educate themselves on anti-fat biases and stereotypes and how they themselves employ them in school or at home. The biases and stereotypes employed by teachers

could have serious impacts on a child's education, particularly when they are already receiving that kind of treatment from their peers. Adults need to step in to reassure students in larger bodies that the bullying they experience simply because of their size is not justified. They need to hear that they are not the problem; the problem is that society supports harmful values.

4. Concluding Thoughts

The time for a cultural revolution regarding societal understandings of fatness is now. Despite some recent acknowledgements in the popular media about, for instance, the inaccuracies of BMI for measuring health, the medical model of fatness continues to exercise great social power. This past February, the American Association of Pediatrics released its first comprehensive guidelines for evaluating and treating children and adolescents with obesity (Hampl et al. 2023). These guidelines advise doctors to consider referring children as young as two years old to "intensive health behavior and lifestyle treatment" programs if they are "overweight" or "obese" (Ibid., 5, 55). For "obese" children ages 12 and up, doctors are encouraged to prescribe weight-loss medications and to offer those over age 13 with "severe obesity" a referral to a bariatric surgery center. This highly interventionist approach to "childhood obesity" overlooks the ways that weight-based stigmatization, bullying, and discrimination affect the well-being of children (Mehl 2023).

Recommending that doctors follow these guidelines is particularly troubling given the considerable evidence suggesting that doctors are the most common source of weight stigma, a fact shown to have detrimental effects on patients' health (e.g., see Puhl & Heuer 2009). Additionally, these recommendations ignore the considerable evidence showing that healthcare interventions are often counterproductive: stigma counteracts a health care provider's attempt to improve health *and* promotes weight gain (Tomiyama et al. 2018), intentional long-term weight loss is rare (Puhl & Heuer 2010), weight stigma is positively correlated with eating disorder symptoms (Puhl 2011), and yo-yo dieting may increase one's risk for cardiovascular disease (Brownell & Rodin 1994). Given these complexities, why is the approach to improving children's health focused on recommending diets, weight-loss medication, and surgery?

If *health* is really the goal, we need to reevaluate the values that have influenced "obesity research" and public health recommendations. Why is there so much backlash for alternative understandings of adipose tissue and its effects on the body when clearly our current approaches to combat the "obesity epidemic" have not reduced the prevalence of larger bodies (and in fact,

the numbers have increased)? If these alternative understandings or approaches to "obesity" will improve people's health by, for example, reducing the prevalence of stigmatization and discrimination, then we owe it to the stakeholders – and especially, *children* – to pursue other research questions, evaluate data differently, and use different models.

Our dominant narrative of fatness has real and extreme consequences on the lives of most Americans. The medical model of fatness has been taken for granted and has unknowingly played a major role in shaping social meanings, values, and practices. Because so much of the social world has been shaped by these meanings, values, and practices, it has real, material effects on society (e.g., on the income, job opportunities, and health of people in larger bodies) which make our social meanings appear justified. While most health care providers, researchers, policy makers, and bioethicists are trying to do right by people in larger bodies, the entrenched medical model of fatness has caused us to overlook things that should be taken as valuable – namely, first-person testimonies of those who experience fat oppression. By promoting a value-neutral model of fatness and encouraging fat pride, we can create a cultural revolution that makes *health* a central goal in public policy, and actually help more people get closer to this goal.

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