FAT LIBERATION OR CO-HEALTHIST COOPTATION? EXPLORING THE LIBERATORY POTENTIAL OF THE HEALTH AT EVERY SIZE FRAMEWORK

by

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in

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Abstract

This thesis interrogates the liberatory potential of Health at Every Size (HAES), a popular framework of care within fat activism. It is a feminist-of-colour disability studies-oriented critical discourse analysis of 100 popular TikToks. The analysis demonstrates that HAES meets some peoples’ urgent needs for care and healing from fatmisia, particularly those who identify with disordered eating and movement. At the same time, the blurry aggregation of health enhancement and social justice in HAES discourse allows health to be weaponized to justify eugenic projects aimed at proliferating perfectible and standardized (‘healthy’) bodies and eliminating bodies marked as deviant or ‘unhealthy.’ The thesis concludes that HAES needs to decentre ‘health’ and instead focus on care to cultivate a fat liberationist and disability justice aligned politic of care and healing as world-building that dismantles health as a prerequisite for worth. A new framework called Care at Every Size (CAES) is proposed.

Keywords: women-of-colour feminisms, fatmisia, healthism, disability justice, fat liberation, mutual aid, collective care, care, healing, world-building, health, feminist-of-colour disability studies, eating disorders, Health at Every Size
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<tr>
<td>HAES</td>
<td>Health at Every Size</td>
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<td>CAES</td>
<td>Care at Every Size</td>
</tr>
<tr>
<td>IE</td>
<td>Intuitive Eating</td>
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<td>IM</td>
<td>Intuitive Movement</td>
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<td>Collective IE/M</td>
<td>Collective Intuitive Eating/Movement</td>
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<td>WHCP</td>
<td>Weight-Centred Health Paradigm</td>
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<td>EDs</td>
<td>Eating Disorders</td>
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<td>ASDAH</td>
<td>Association For Size Diversity and Health</td>
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<tr>
<td>CDA</td>
<td>Critical Discourse Analysis</td>
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<tr>
<td>BIPOC</td>
<td>Black, Indigenous, and People of Colour</td>
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## Glossary

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<th>Term</th>
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<td>Mad</td>
<td>‘Mad’ is a reclaimed label for psychiatrized, consumer, and/or neurodivergent people to self-identify with that allows for pride and political identification that is anti-psychiatric domination and institutionalization.</td>
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<tr>
<td>Crip</td>
<td>Reclaimed label for Mad, disabled, and/or chronically ill folks to self-identify with that allows for pride and political identification. It is inherently anti-normative. It is also a verb (to crip something) that means to destabilize or disorient common conceptualizations in such a way that centres crip ways of living, knowing, and being and positions crip lives as valuable and desirable.</td>
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<tr>
<td>Health at Every Size (HAES)</td>
<td>Framework of healthcare and health promotion that frames health as size-inclusive and pushes for access to quality healthcare and health-capacitating environments for people of all sizes. Trademarked by the Association for Size Diversity and Health (ASDAH).</td>
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<tr>
<td>Anti-fatness</td>
<td>An alternative to ‘fatphobia,’ which medicalizes and individualizes anti-fat bias and hate, anti-fatness is an umbrella term for “the attitudes, behaviours, and social systems that specifically marginalize, exclude, underserve, and oppress fat bodies” (Gordon, 2021, para. 14).</td>
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<tr>
<td>Fatmisia</td>
<td>Means fat hatred. It can be defined as “prejudice plus power […] in North America and across the globe, thin people have the institutional power, therefore Fatmisia is a systematized discrimination or antagonism directed against fat bodies/people based on the belief that thinness is superior” (Simmons University Library, 2023, para. 2). Rinaldi et al. (2020) define it as a “complex affective force” (p. 37) that “flows across, attaches to, and comes to define or value different bodies” (p. 37).</td>
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<tr>
<td>Diet culture</td>
<td>System of beliefs that valorizes thinness and equates it to health and moral virtue; promotes weight loss as social status; demonizes certain ways of eating and exercising while valorizing and prescribing others; oppresses those who are not clocked as ‘healthy’ under its scope (C. Harrison, 2018).</td>
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<tr>
<td>Co-healthism</td>
<td>A term I coin in chapter two: a web of oppressive systems where anti-Blackness, white supremacy, anti-fatness, ableism, colonialism, and neoliberalism mutually reinforce one another to require ‘health’ as an individual imperative and prerequisite to valued subjecthood and prescribe “health promotion” via the perfection of some bodies and elimination of others, both of which are positioned as essential to the moral and biological betterment of society. Through co-healthism, health</td>
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is understood as ‘normal’ (ideal) embodiment that can or should be strived for or is achieved through ‘good’ or ‘proper’ behaviour and Western biomedical intervention. Co-healthism propagates eugenic projects (called health promotion) and is both buttressed by and buttresses interlocking systems of oppression to preclude systems-level analyses that would benefit marginalized people’s wellness and healing and challenge the status quo. It also actively harms people’s wellness and effectively disables and kills marginalized populations, with those furthest from ideal embodiment facing disproportionate penalties. It is paradoxical because although co-healthism requires everyone to pursue ‘health’ in an attempt to find inclusion and safety within the state (and the presentation of ‘health’ does provide limited safety and access to power) because the category of ‘health’ is defined based on one’s proximity to normal (ideal) embodiment (whiteness, thinness, able-bodiedness), non-normative bodies will always be coded as unhealthy. This ubiquitous presence of “unhealthiness” is then used to reinforce and justify co-healthist domination and control by presenting it as a benevolent world-building project.

Care at Every Size (CAES) An evolution to HAES that is proposed in this thesis. It is a framework of care, fat liberation, and disability justice that abolishes health as a prerequisite for worth and organizes for access to quality care, healing, and wellness capacitiation for all. Care under this framework includes healthcare but also includes crip notions of cathartic collective care. Under this framework, well-being is understood as mainly systemically (politically, socially, and environmentally) determined.

Intuitive eating (IE) and intuitive movement (IM) Interventions against diet culture that are popular in eating disorder care. Each have a set of principles that centre agency, intuition, desire, freedom, gentle guidance, and pleasure in personal eating and movement practices and do not moralize bodies, food, or exercise.

Collective intuitive eating/movement (IE/M) Based in a cathartic collective care philosophy, it is a feminist-of-colour disability studies-oriented prototype for healing as world-building that is anti-curative imaginary (Kafer, 2013), meaning it sees disabled and Mad people in the future and as desirable for a liveable world. It works to help people affected by (internalized) anti-fatness, particularly those who identify with disordered eating and movement, to heal. It centres collective action and decision making, cathartic collective care, food sovereignty, decolonization, abolition, and mutual aid. It is prefigurative politics that enacts a liveable world and capacitates people to continue disability justice and fat liberationist world-building.
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<tr>
<td>Cathartic Collective Care</td>
<td>Emphasizes joint accountability and group bearing of trauma that facilitates interdependence, mutual aid, collective empowerment, and collective organizing, which offer affective release and healing. It is an alternative to mandated medicalized and psychiatrized care. It is in part characterized by shared experiences of pain, grief, shame, and anger affected in communities by systems of oppression, in this instance, (internalized) anti-fatness. It is the care philosophy that underpins collective IE/M.</td>
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<tr>
<td>TikTokers/content creators/posters</td>
<td>Interchangeable terms for people who make and share videos and/or other content on TikTok.</td>
</tr>
<tr>
<td>Hashtags</td>
<td>Words or phrases used to tag content on social media. They act as a way for content creators to index, market, and disseminate their content.</td>
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<tr>
<td>Feminist-of-colour disability studies</td>
<td>A political and theoretical project that utilizes disability as a productive lens to look at how interlocking systems of oppression aggregate to assign varying worth to certain bodyminds (Schalk &amp; Kim, 2020). It was coined by Schalk and Kim (2020) but is based in long histories of woman-of-colour feminisms and queer and crip of colour critiques that do not theorize around single-identity categories or single political issues.</td>
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<tr>
<td>Bodymind</td>
<td>A term coined by Price (2015) that challenges body/mind dualism and marks their inextricability and interconnectedness.</td>
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<tr>
<td>Fat liberation</td>
<td>A fat activist movement committed to the liberation of fat bodyminds and the eradication of systemic anti-fatness and fatmisia. It is fundamentally collective and coalitional and committed to cross movement organizing.</td>
</tr>
<tr>
<td>Disability justice</td>
<td>A crip world-building movement and radical activist practice created by queer, trans, and BIPOC disabled people historically marginalized in the disability rights movement (Berne, 2020; Lamm, 2015; Sins Invalid, 2016). Disability justice centres multiply marginalized peoples and is anti-normative, abolitionist, and radically transformative (Berne, 2015). This movement has ten principles: intersectionality, leadership of those most impacted, anti-capitalist politic, commitment to cross-movement organizing, recognizing wholeness, sustainability, commitment to cross-disability solidarity, interdependence, collective access, and collective liberation (Berne, 2015).</td>
</tr>
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Introduction

To ‘recover,’ I tell friends and family
No fat hatred around me
No diets
Or poor self-esteem.

Self-help books, podcasts,
Curated social media,
Therapy, more therapy
On repeat
You deserve to eat
Your body is an instrument
Not an ornament
Love it.

Meditation in motion
Manage your emotions
Eat what you want
Just stop when you’re full
Exercise for feeling good not right
Health at Every Size!

Remember: “I have the best body to live my best life,”
“Clothes are meant to fit you
Not the other way around.”
But when I go to the mall
Nothing fits at all…
So I stop shopping with my friends.

At work—no boundaries—
Diet culture all around me
I tell myself it’s all bullshit.
But they hate themselves
And they’re thinner than me
They skip lunch
Drink more caffeine
Comment on how much I eat
In the ‘real’ world I cannot curate my feed,
To them, my body is an apology.

So, again, I become one.

My best friend too
Starts feeling out of control with food
She says she misses her old body.
I can only feel that she hates mine
And set a boundary for a thousandth time
But tell her to read “Anti-Diet.”
She did.
Did it work for her?

For anyone who has been a part of the Health at Every Size (HAES) online community, many of the phrases from this poem will sound familiar. Popular in anti-diet spaces and eating disorder (ED) care, HAES is a framework of care and activist paradigm that advocates for healthcare and health promotion to become size-inclusive. As a framework that attempts to do healthcare and health promotion the ‘right’ way, it often perpetuates systems of oppression that moralize and individualize health and wellness. At the same time, it is loved by many as a fat-accepting space because it offers its supporters a semblance of food and exercise ‘freedom’ in a world that demands that everyone, but fat people especially, restrict and carefully control our food intake and obsess over exercise. It also paves the way for fat people to receive healthcare that does not harm or seek to erase us. HAES was my first introduction to fat activism and a necessary, albeit limited, tool for survival in a fatmisic world. HAES ideology and community propelled me into fat liberation and fat community. This thesis is primarily born out of my love for, and eventual disillusionment with, HAES. It is a feminist-of-colour disability studies-oriented TikTok critical discourse analysis (CDA) born out of fat crip community and care. It has been enabled by all the activists, scholars, thinkers, professors, and friends who have given me the language to complete this work. Throughout working on this project for nearly two years, my thoughts on HAES, health, wellness, disordered eating, care, healing, fatness, disability, and Madness have had countless evolutions and transformations. Studying and researching with decolonial and woman-of-colour
feminisms, critical disability studies, and fat studies have made this transformation possible. It brings me much joy to know that this thesis will offer even a fraction of the expansions I have had the privilege of experiencing to at least a few others.

Along with these joys, my analysis has led me to a challenging conclusion. Because of the ongoing oppressive and eugenic roots of colonial health promotion, which I discuss in chapters one and two, imagining a future for HAES that does not propagate the interlocking systems of oppression is very difficult. At the same time, people need care, and HAES supporters do not seem ready to give up on the framework. Presently, one thing remains certain: HAES supporters’ discursive power to expand and justify systemic violence needs to be marked and challenged. To accomplish this, this thesis maps how co-healthist violence operates in the specific realm of online space—more precisely, on TikTok. This mapping amasses my conclusion that HAES needs to shift from focusing on health to instead focus on care. Care that is performed in our current world order is not unproblematic and careful attention to power relations within care webs and relationships must be carefully attended to. But care is political and “fundamental to life” (Douglas et al., 2017, p. 2). It is central to disability justice and fat liberation ideology and, unlike health promotion, can be done in a way that inherently values all bodyminds as whole. This conclusion around care gave rise to the idea for a new framework that centres fat and crip notions of care and healing as world-building, which I call Care at Every Size (CAES).

**Problem Statement and Research Implications**

Starting with my lived experience of the liberatory potential of HAES, I set out to uncover how it is popularly understood, practiced, disseminated, and advocated for, as
well as examine the discursive effects of these articulations and practices. My objective was to understand the relations of power embedded in popular HAES discourse in order to come to a conclusion about its liberatory potential and place in fat activism. I also wanted to specifically address the tensions between the importance of advocating for health equity and health-capacitating environments alongside the importance of recognizing the dangers of devaluing the lives of chronically ill, Mad, and disabled people. To accomplish my objectives, I developed three research questions and examined the top 100 TikToks under a popular HAES hashtag: 1) What positionalities advocate for HAES on TikTok, and how are they speaking about/framing it? 2) What are the potentialities, limitations, and harms of how the HAES framework is popularly articulated on TikTok? 3) How can HAES discourse shift productively by centring a feminist-of-colour disability studies lens? I detail my chosen theoretical orientation thoroughly in chapter one, but feminist-of-colour disability studies is essentially a political project that utilizes disability as a productive lens to look at how interlocking systems of oppression aggregate to assign varying worth to certain bodyminds (Schalk & Kim, 2020). It was coined by Schalk and Kim (2020) but is based in long histories of woman-of-colour feminisms and queer and crip of colour critiques that do not theorize around single identity categories or single political issues. I chose to conduct my research on TikTok because of its open-access, popularity, and highly collaborative nature, which I also outline more in chapter one.

My chosen theoretical orientation, methodology, and methods allowed me to uncover that while HAES is framed as helpful and liberatory by many, it is mostly white feminine and female-presenting people who advocate for it, and this advocacy is steeped
in white feminism, ableism, white supremacy, and colonialism. These oppressive ideologies dominate the popular support for HAES on TikTok and demarcate health as biomedical, morally imperative, and apolitical, as well as reify health as a prerequisite to worth. HAES’ tethering to ‘health’ is a large source of its limitation and violence because it leaves room for and encourages discourse that supports eugenic projects that aim to proliferate standardized and perfectible bodies (coded as healthy) and eradicate bodies marked as unhealthy (BIPOC, super/infinifat, disabled, chronically ill, and Mad bodies). The narrow framing of ‘health’ and the prescribed imperative for ‘good health’ present in the data both arise from and strengthen the discursive power of interlocking systems of oppression to privilege hegemonic bodies and penalize and eradicate bodies that deviate from the norm. On a conflicting note, my research also shows that there is a large community of people harmed by anti-fatness and thin valorization for whom the online HAES infrastructure is a place of redress from fatmisia and the cultural imperative to starve, restrict, purge, and compulsively, obsessively, or stressfully exercise. It is also a place where people come together to care for themselves and one another, as well as form community where people can share their lived experiences of pain and resistance and heal from internalized anti-fatness. Accordingly, HAES cannot be simply deemed as ‘good’ or ‘bad,’ and this research clarifies this.

Without carefully exploring the harms, limitations, and potentialities of HAES, there is a risk of either accepting it flaws and all or abandoning the people who need and desire the care it offers. There would be harmful consequences if HAES discourse continues to operate as it does currently or if its principles were abandoned full stop and deemed entirely oppressive. Suppose HAES discourse continues to be dominated by
white feminism, ableism, white supremacy, and colonialism and require health as a prerequisite for worth. In that case, it will continue to exclude and actively harm those most impacted by medical anti-fatness (BIPOC, super/infinifat, disabled, chronically ill, and Mad people). It will also strengthen discourse that justifies eugenic projects as necessary for the health of society while masking their violence as social justice. On the other hand, if HAES is parochially deemed problematic and consequently squashed, its potential to offer immediate care and community to those harmed by systemic anti-fatness will be lost and the people benefitting from it would have to choose between continuing to participate in HAES’ violence or give up the healing it offers them.

Through feminist-of-colour disability studies-oriented CDA, this thesis makes clear the need for organizing, policy, infrastructure, and community that contemplates HAES’ liberatory potential holistically and takes the harm it engenders seriously while recognizing its value and potentialities. It makes clear exactly what HAES’ harms, limitations, and potentialities are in order to make recommendations for the future that are informed by cross-movement solidarity and coalitional politics. I am not calling for an abandonment of wellness seeking, formal healthcare, self-care, individual health-promoting behaviours, or seeking relief from pain and distress. What I am calling for is a feminist-of-colour disability studies-oriented expansion of what these practices look like.

This research is important for critical health studies, fat studies, disability studies, mad studies, and woman-of-colour and decolonial feminisms for several reasons. First, it bridges these disciplines by using a feminist-of-colour disability studies understanding of disability as a lens and method and demonstrates the liberatory potential of doing so. Second, it applies this coalitional methodology to HAES scholarship specifically, which
current literature lacks. Third, it makes clear how central oppressive ideology is to
HAES’ popular deployment on TikTok. Fourth, it elucidates the limits of ‘health’
advocacy, equity, and activism by expanding the definition of healthism to mark how
even in activist spaces, the language of ‘health’ makes it easy for co-constituting systems
of oppression to justify and carry out eugenic projects disguised as social justice. Fifth, it
documents the knowledge and experiences of those who have found community, redress,
catharsis, and healing through HAES but does so critically and does not make excuses for
the violence that the framework engenders. Sixth, because of the violence that the
language of ‘health’ engenders, this thesis provides a conceptual prototype for activists
concerned with advocating for wellness-capacitating environments and access to quality
healthcare that is informed by an anti-curative imaginary (Kafer, 2013) and fat and crip
notions of healing as world-building. Seventh, it imagines a future for HAES ideology
and HAES supporters that is capable of bringing to life fat liberationist and disability
justice principles where multiply marginalized fat and disabled people are not just
tolerated but valued. In sum, it uses feminist-of-colour disability studies theorizing to
strongly argue against associating social justice initiatives with ‘health’ promotion and
enhancement. Still, it does not dismiss people’s needs for care, desires to improve health
biomarkers, or movements for wellness-promoting environments. It does this by arguing
for the need to shift from ‘health’ activism to care activism. This insight is essential to fat
and crip communities, social justice-related fields, health fields, and health activism
because it targets the violence of ‘health’ discourse at its roots while modelling a path to
facilitating widespread physical, psychological, and emotional well-being for
marginalized peoples.
Chapter Summaries

In chapter one, I provide a background of the following: the problem of anti-fatness in healthcare and health promotion; the purpose of HAES as an intervention against this problem; current HAES literature and the need for further research; my theoretical orientation, feminist-of-colour disability studies; my positionality and practice of uncomfortable reflexivity; my methodology, TikTok CDA; and my methods to help readers critically engage with my research. Chapter two addresses my first and second research questions and carries out a mixed-method approach to feminist-of-colour disability studies-oriented CDA. It begins by discussing the statistical analysis of the TikTok engagement metrics and TikToker positionalities as well as the mixed-method analysis of the other hashtags present under the TikToks. The quantitative analysis provides a digestible snapshot of my first research question that supports and provides context for the qualitative portions of my analysis. Through it, I show how HAES discourse is dominated by white feminine and female-presenting people who associate HAES with ED care, apolitical body politics and health promotion, and fat liberation simultaneously. I then carry out my qualitative analysis for my study of what HAES is doing discursively. For question two, I focus my analysis in this chapter on the limitations and harms of HAES discourse. I make clear how the current definition of healthism needs to be expanded to address the centrality of anti-Black racism, white supremacy, colonialism, and ableism in healthist ideology, discourse, and practices. I propose a feminist-of-colour disability studies-oriented shift towards looking at ‘health’ as a lens or method for examining how under our current world order, the interlocking systems of oppression mutually reinforce one another to require ‘normal’ (ideal) embodiment as a
prerequisite to worth and valued subjecthood. I coin the idea of “co-healthism,” define it, and demonstrate how it enables the execution of the former task. I ultimately argue that HAES supporters on TikTok have coopted fat liberation’s world-building goal through and with co-healthism to mutate it into health promotion, effectively furthering co-healthist eugenic projects under the guise of beneficial and necessary social transformation.

In chapter three, I further my CDA but focus on the remaining part of my second research question; the potentialities of how the HAES framework is articulated on TikTok. I also further my third research question and imagine how HAES discourse can shift productively by centring a feminist-of-colour disability studies lens. Through my analysis of the same 100 TikToks, I argue that HAES provides cathartic community care for those distressed by (internalized) anti-fatness, particularly people who identify with disordered eating and movement. The HAES digital landscape offers people distressed by anti-fatness and food, exercise, and body preoccupation a community to process and share their emotions and receive community care in the process. It also maps out ways of eating and moving not governed by anti-fatness and diet culture. Intuitive eating (IE) and intuitive movement (IM), two current principles of HAES, largely capacitate this. However, given that co-healthist domination within the framework has made it exclusionary and harmful to anyone who cannot assimilate into ‘normal’ (ideal) embodiment (BIPOC, super/infinifat, disabled, chronically ill, and Mad bodies), this potentiality cannot result in meaningful social transformation or fat liberation under HAES’ current iteration. So, I put forward a fattened andcripped iteration of IE and IM based in collective care, food sovereignty, mutual aid, healing as world-building, and
radical solidarity that I call “collective intuitive eating/movement (IE/M).” This analysis challenges the medicalized and psychiatrized ED ‘recovery’ narrative in favour of crip healing. Under collective IE/M, ‘healing’ is conceptualized using disability justice ideology that does not devalue or aim to eradicate bodymind difference. It rather positions fat, disabled, and Mad people as present and desirable in the future and essential to building a liveable world. Collective IE/M both carries out collective abolitionist world-building and capacitates individuals and collectives to continue this work. Collective IE/M falls under a metamorphosis of HAES, CAES, which I explain in the conclusion chapter.

In the conclusion chapter, I summarize the key takeaways that my project has given rise to. I also provide my thoughts on the future- or problem of- HAES. Given the propensity towards harm present in HAES discourse, current moves by its governing body to evolve it have clearly not taken effect thus far. I provide my thoughts on whether the framework can be fixed or improved or whether it is time for its supporters to move on. I ultimately conclude that to allow for the enactment of fat liberation and disability justice principles, which are needed for the framework to liberate the most marginalized, HAES needs to decentre health from its purpose and instead centre care. To do this, I propose a new framework called CAES. I want to conclude this introduction by professing my hope that this thesis propels HAES supporters and critics to take accountability in the present and dream big for the future. I hope you will join me in building an anti-curative imaginary and liveable world marked by coalitional resistance and collective care.
Chapter One: Background, Theory, and Methods

Anti-fatness in Healthcare and Health Promotion

Anti-fat bias is rampant within health sciences, and the field is dedicated to proliferating poor quality fatmisic science buttressed by the dominant discourse that being fat causes disease and that fat people should always be attempting to lose weight (Bacon & Aphramor, 2011; Campos et al., 2006; Chrisler & Barney, 2017; O’Hara & Gregg, 2012; O’Hara & Taylor, 2018). Health is frequently articulated as dependent on weight, fatness is continuously pathologized, and weight loss through dieting and exercise regimens is pervasively prescribed as essential to positive health outcomes and full lives. These processes result from the weight-centred health paradigm (WCHP), which positions weight as the essential paradigm for “thinking about and talking about health” (O’Hara & Taylor, 2018, p. 1). This paradigm is the most popular and widely accepted within healthcare and health promotion, although there is growing evidence that fatness is not inherently pathological; weight loss regimens do not work; individual and environmental attempts at preventing and reducing fatness do not work; prescribing weight loss is dangerous and results in poor health outcomes; prescribing weight loss promotes weight cycling and overall weight gain; weight inclusive paradigms promote better and sustained health outcomes (Bacon & Aphramor, 2011; Berg, 2017; Bombak, 2014; Campos et al., 2006; Chrisler & Barney, 2017; Lyons, 2009; Mackert & Schorb, 2022; Tomiyama et al., 2013; van den Berg & Neumark-Sztainer, 2007).

Campos et al. (2006) found that there is insufficient evidence to demonstrate that fatness is an epidemic; high adiposity is pathological or directly causes disease; fatness is a key predictor for mortality risk; or that “significant and long-term weight loss is both
medically beneficial and a practical goal” (p. 55). Tomiyama et al. (2013) echo these assertions, as their research indicates that studies done on dieters find very little improvement of health outcomes and that when improved health markers occur, they are not correlated with weight loss. Moreover, studies that undertake long-term follow-up demonstrate that most people regain almost all weight lost within five years of the initial intervention (Mann et al., 2007; Miller, 1999). As a further matter, weight loss has not been shown to prolong life and focusing on weight loss interferes with the formation of more holistic and realistic health goals (Bacon & Aphramor, 2011).

Bacon & Aphramor (2011) also found that the pursuit of weight loss most commonly results in weight cycling rather than long-term weight loss or decreased morbidity and mortality. This means that individuals will go through periods of repetitive weight loss followed by weight gain, and this cycle has been shown to increase risk of cardiovascular disease and hypertension as well as all-cause mortality risks (Bacon & Aphramor, 2011; Zou et al., 2019). Intentional weight loss is also linked to reduced bone mass, which increases one’s risk for osteoporosis (Bacon et al., 2004). Further studies also show that pursuing weight loss increases stress and stress-related disease risk, promotes poor body image and self-esteem, increases the risk of being diagnosed with an ED, and is associated with increased long-term weight gain (Neumark-Sztainer et al., 2006; Tomiyama et al., 2010; van den Berg & Neumark-Sztainer, 2007). Additionally, health promotion that focuses on weight loss is also linked to depression and malnourishment (O’Hara & Taylor, 2018).

Importantly, the WCHP is not only lacking in scientific justification, but it also increases discrimination and stigma against fat folks. The anti-fatness embedded in
healthcare and health promotion creates many health hazards for fat people, such as healthcare avoidance, increased stress, inaccessible offices and equipment, subpar healthcare, biased attitudes and abuse from physicians, and misdiagnoses (Chrisler & Barney, 2017). Experiences of anti-fatness are also compounded by intersecting experiences of oppression, such as racism, classism, sexism, and transphobia (Chrisler & Barney, 2017). The documented harm that comes from perpetuating anti-fat science, bias, and attitudes means that researchers and practitioners working within public health must acknowledge that focusing on people’s weight or using a WCHP may breach their “legal and ethical human rights obligations” (O’Hara & Gregg, 2012, p. 42). Systemic anti-fatness in health sciences, healthcare, and health promotion is thus an indisputable and pressing social justice concern.

Despite the lack of high-quality scientific evidence supporting a WCHP, and the plethora of studies against it, weight loss continues to be ubiquitously prescribed. If fatness has no direct causal relationship to morbidity or mortality, and pursuing weight loss does not work and causes poor health outcomes, how could the health sciences community continue pushing the WCHP? If the WCHP is based on biased poor-quality science, how can its supporters continue their positivist practices? One key reason is that the WCHP is highly profitable because weight loss interventions do not work; people must continuously purchase them throughout their lives. Lyons (2009) says:

It is important to realize that were it not for weight bias, weight loss programs would wither and die because they consistently fail to produce lasting weight loss. If concern for health is truly the primary motivator, then reducing fat stigma would be at the top of the list for health activism. Instead, research has identified
weight bias in virtually all health professionals—physicians, nurses, dietitians, and therapists—including those who specialize in obesity treatment (Schwartz et al., 2003). Thus weight bias has been a cornerstone of public health policies so far, and drug industry profits have been inflaming these efforts. (p. 85)

So, ultimately, the WCHP prevails because it is a belief system embedded in and allowed by fatmisia, ableism, white supremacy, colonialism, capitalism, and intersecting systems of oppression. These systems propagate oppressive hierarchies, systemic violence, and social control that ultimately call for the subjugation, exploitation, and erasure of bodyminds marked as deviant under these systems (ex. BIPOC, disabled, and fat people). Mainstream health promotion that occurs through the WCHP is thus one of many examples of contemporary eugenic projects, which I will expand on and properly elucidate in chapter two. Evidently, critiquing the WCHP, while necessary to a certain extent, has not produced significant changes to healthcare or health promotion or addressed the interlocking systems of oppression that make this paradigm possible. Those engaged in a fat politic must look critically at our liberatory projects, centre our own movements in our critiques, and move beyond reform to imagine radical futures (Brady & Gingras, 2018; D. Harrison, 2021; Meleo-Erwin, 2012). Fat politics addressing diet culture, medical bias, and health equity have focused largely on Health at Every Size (HAES) as a critical site for combatting anti-fatness in healthcare and health promotion. As such, I am interested in examining HAES’ potential for combatting fatmisia in healthcare and promotion, but also fat liberation more broadly.
What Is Health at Every Size (HAES)?

Despite the cohesive core principles, the HAES movement is diverse and includes perspectives from theory, clinical practice, and activism (Brady & Gingras, 2018). HAES discourse marks systemic anti-fatness as a human rights violation and responds to it by reconceptualizing health and capacity as weight-inclusive, opposing weight loss prescription, and challenging body size oppression (O’Hara & Taylor, 2018). It also encourages health promotion strategies not centred around weight loss, such as encouraging IE and IM for people of all sizes (Cain & Donaghue, 2018; Chrisler & Barney, 2017; O’Hara & Gregg, 2012). However, HAES is now a trademarked framework for care owned by the Association for Size Diversity and Health (ASDAH). While trademarked, ASDAH describes HAES as “a continuously evolving alternative to the weight-centred approach to treating clients and patients of all sizes” (Association for Size Diversity and Health [ASDAH], n.d.-a, para. 2). However, the framework is not exclusive to formal healthcare and can be used as a health promotion paradigm by individuals seeking health: “The HAES® Principles also provide a framework of care for providers and individuals to approach health without a focus on weight or weight loss” (ASDAH, n.d.-a, para. 19, emphasis added). This same page also notes that focusing on healthy habits promotes health more effectively than focusing on weight. They state:

We are first and foremost about increasing access to quality healthcare for fat people. We also offer a framework for care to help providers and patients think about health from a lens of fat liberation. Neither of these require fat people to pursue health or attain a ‘healthy’ status (para. 23, emphasis added).
So, while the language ‘framework for care’ and ‘treatment’ appear to centre formal medical care and the health professionals providing it, HAES is evidently concerned with intervening in public health discourse surrounding health promotion and individual health behaviours.

ASDAH is clear that HAES is not a social justice movement itself but rather is a framework aligned with social justice. However, this aggregation of health promotion, health enhancement, health equity, liberation, individual behaviours, community care, and healthcare means that HAES can be (and is) understood by its supporters as social justice. In the previously presented quote, ASDAH explicitly claims that HAES aligns with or is based on a fat liberation ethos. In paragraph 14 from the same source, while discussing what health enhancement means to them, they state: “…one of, if not the, most important ways to improve health is by eliminating oppression. Fatphobia and weight bias are intimately connected to all other forms of oppression, especially racism” (emphasis added). The assertion that HAES is merely a framework for care and not a social justice movement, paired with the assertion that eliminating oppression is the most crucial way to promote health, complicates their mission and intended goals. So does their stretch from formal medical care towards public health and individual health behaviours, health equity and access, and the political, environmental, and social determinants of health. They make this jump by saying that “Health Enhancement covers a huge range of topics from health equity to the social determinants of health to community care to individual approaches to health” (para. 14, emphasis in original).

ASDAH is currently in the process of updating HAES’ core principles, which are presently: weight inclusivity, health enhancement, eating for well-being, respectful care,
and life-enhancing movement (ASDAH, n.d.-c). Importantly, because they frame health enhancement as political and centred on eliminating oppression rather than individual pathologies, HAES is overtly anti-healthism and opposes deeming individuals morally responsible for their health or blaming them for sickness. This means that, among what has already been mentioned, HAES advocates for accessible healthcare; abolition of fatmisia and intersecting forms of oppression within healthcare and beyond; weight-inclusive health promotion strategies; and informed consent and bodily autonomy for healthcare consumers (ASDAH, n.d.-c). According to ASDAH, the framework is intended to centre the knowledge and priorities of those with the least power and privilege under interlocking modes of oppression.

It is important to note that healthy eating and exercise are conceptualized differently under HAES than a WCHP. Under HAES, healthy eating is based on IE, and people are taught to eat flexibly and go off of hunger cues, pleasure, satiety, and individual nutritional requirements rather than a diet or meal plan that moralizes food (O’Hara & Taylor, 2018). Moreover, life-enhancing movement is different from traditional exercise practices because it focuses on promoting activity that is enjoyable and appropriate for each individual (O’Hara & Taylor, 2018). IM considers ability, size, and interest and asserts that individuals can choose to move according to whatever degree they desire. While eating for well-being and life-enhancing movement align with a HAES approach, ASDAH has stated they will likely remove them as core principles because “many people do not have access to or do not prioritize these aspects of wellbeing” (ASDAH, n.d.-c, para. 9). These approaches will likely remain in HAES discourse but will be included as tools rather than core principles.
In sum, HAES frames health promotion as eliminating oppression, which is in
staunch comparison to traditional iterations of it as eugenic practices aimed at eliminating
biological and moral ‘defects’ and proliferating standardized and perfectible bodies. By
presenting alternative definitions for traditionally violent terminology, ASDAH, via
HAES, creates a complicated space where the lines between health promotion as
eugenics and health promotion as health equity and social justice become blurry. ASDAH
defines health as a resource or capacity that exists on a continuum and not a moral
imperative (ASDAH, n.d.-c), which does not moralize health or devalue chronically ill or
disabled people. However, they are attempting to completely redefine and reform fields
of study rooted in eugenic ideology and praxes without fully attending to these histories.
Eugenic definitions are not the only or the correct definitions of health and health
capacitation. However, as discussed in chapter two, they are the ones that have
propagated biomedicine and public health and extended their reach globally via colonial
domination. Most individuals looking to learn about or make decisions concerning health
and health enhancement are not finding ASDAH as a first or primary resource. At the
same time, political action that capacitates access to healthcare, wellness, well-being,
healing, and environments that promote them are an essential part of social
transformation. People need care, and we deserve quality care. I intend to explore this
debate in such a way that attends to violent eugenic histories, contexts, and contemporary
projects while also carving out room to imagine a world where wellness and healing do
not mean erasure and eradication, one where every bodymind can access them as
resources, capacitation, and disability justice and fat liberationist world-building.
Addressing the Gaps in Existing HAES Literature

A HAES approach has been found to be more effective than a WCHP at improving various aspects of holistic health and health-promoting behaviours in the long term (Bacon et al., 2005; O’Hara & Gregg, 2012; O’Hara & Taylor, 2018). Fat studies scholarship has shown that HAES can fight weight discrimination and provide more effective, safe, and permanent ways of improving health than methods focusing on weight loss (Bacon et al., 2005; Bacon & Aphramor, 2011; Berg, 2017; Chrisler & Barney, 2017; O’Hara & Gregg, 2012; O’Hara & Taylor, 2018). IE, a core principle of HAES, has also been found to reduce what is understood as disordered eating (Bacon & Aphramor, 2011; Provencher et al., 2009; Tylka, 2006). The support for HAES extends outside of the sciences as well. Cain and Donaghue (2018) conducted focus groups and found that HAES discourse was easily accepted by participants as a practical and convincing alternative to the WCHP and believed that it could positively impact people's health and reduce the stigma and discrimination that fat people face.

Even those critical of the potential healthism embedded in HAES admit its utility and effectiveness (Cain & Donaghue, 2018; Lebesco, 2010). To repeat myself, while coupling health promotion with fat liberation creates a messy, complicated, and potentially ableist and healthist terrain, those engaged in a fat politic must not entirely dismiss the material benefits to people's lived realities that can come with wellness-promoting behaviours and environments. While Lebesco (2010) is adamant that those engaged in the size acceptance movement centre how health is moralized and how the requirement to perform health behaviours is weaponized as a prerequisite to being deemed a proper citizen, she notes that to “glibly dismiss the material reality of ‘good
health’ requires a privileged position” (p. 78). Again, most definitions of ‘good health’ are steeped in ableism, but if we conceptualize health using ASDAH’s definition, the health-promoting potential of HAES is clear. Berg (2017) also challenges the moralization of health and advocates for individual free choice but says this choice can only happen with an education overhaul dedicated to weight-inclusive health paradigms that address the socioeconomic and political determinants of health. The widespread implementation of HAES has the potential to benefit the lives of some fat people materially and could reduce discrimination and oppression within healthcare and health promotion. It could also reduce or prevent the physiological and psychological harms associated with the WCHP. In sum, the literature is clear – there are harms and failures to the WCHP. There are also copious benefits and efficacy to utilizing a HAES framework. It is, however, crucial to highlight that when evaluating HAES’ efficacy, studies have focused on individual behavioural modifications and markers of individual health. This is a significant limitation given that health is a community project (Kaba & Hassen, 2019) and is largely socially, politically, and environmentally determined. Systems-level analysis of HAES’ liberatory potential is therefore needed.

To go hand-in-hand with systems-level analysis, there is also currently a need for critical inquiry into the potential harms and limitations of HAES. Several scholars remain skeptical about HAES’ potential to challenge ableism, white supremacy, colonialism, and healthism (Aphramor, 2020; Brady & Gingras, 2018; Cain & Donaghue, 2018; Ferguson, 2012; Gibson, 2022; Mackert & Schorb, 2022; Meleo-Erwin, 2012; Welsh, 2011). However, the majority of this work focuses discreetly on healthism and ableism. Scholarship has focused on HAES’ perpetuation of healthism and assimilationist goals
and marked how failing to challenge healthism leaves behind those who cannot or will not pursue health via individual behavioural modification (Cain & Donaghue, 2018; Gibson, 2022; Mackert & Schorb, 2022; Meleo-Erwin, 2012; Welsh, 2011). This insight is crucial to understanding HAES’ liberatory potential and place in fat activism. Nevertheless, the limited critical scope is notable given that HAES discourse has historically been dominated by white women and built from a white standpoint with white priorities (ASDAH, n.d.-b). For example, HAES has had white exclusive representation and erased the needs of non-white people through single-issue politics. Considering the breadth of literature supporting the implementations of a HAES framework, there is a significant gap regarding its potential to galvanize systems-level change, produce fully transformative social liberation, and benefit those who live in the intersections of multiple systems of oppression. Critical disability studies, critical race theory, and decolonial and woman of colour feminisms have also been neglected in scholarship on HAES, as have analyses that holistically address the co-constitution of oppressive systems. This is of particular concern given ongoing debates among scholars pointing to HAES’ enmeshment with healthism because no system of oppression can be understood discreetly. Ableism, anti-Blackness, white supremacy, and colonialism shape how health is defined and prescribed, so research on HAES that attends to these interconnections is needed.

Additionally, HAES is a framework of healthcare and health promotion adopted by individuals for their own lives as well as doctors, nutritionists, dieticians, personal trainers, researchers, educators, content creators, and activists. So, specific research exploring who is using it, advocating for it, and how they are doing so is needed because
it is ultimately a collection of individuals’ practices that shape its impact. ASDAH can redefine health, health promotion, and its principles to increase HAES’ liberatory potential and address the harm it has historically engendered. Still, these changes may not translate to practitioners’ understandings and performances of the framework. Finally, given HAES’ evident potential and harm, I believe research is needed that balances how HAES benefits so many people with how it (re)creates and perpetuates systems of oppression.

**Theoretical Orientation: Crippling HAES with Feminist-of-Colour Disability Studies**

Feminist-of-colour disability studies is a “critical methodology and political category” (Schalk & Kim, 2020, p. 32) that can be utilized by people with any positionalities, meaning it is not only for women-of-colour or disabled people. It is an “intellectual, theoretical, and political project” (Schalk & Kim, 2020, p. 32) that recognizes the critical race theory already present in disability studies, conceptualizes feminist-of-colour literature not overtly about disability as disability scholarship, and reshapes feminist disability studies by challenging the whiteness that shapes the field. It aims to integrate race into feminist disability studies so that race is not merely considered or added as a frame of analysis but rather becomes central to the field’s citational politics (Schalk & Kim, 2020).

This theoretical orientation frames disability studies as a method or lens for unpacking how “ableism, heteropatriarchy, white supremacy, and capitalist violence” (Schalk & Kim, 2020, pp. 37-38) intersect and mutually reinforce one another to assign varying value to particular bodyminds. It thus draws from feminist, queer, and crip of-colour critiques that theorize and organize around proximity to power instead of shared
identity (Cohen, 1997; Kim, 2017). It conceptualizes "(dis)ability as a social system"
(Schalk & Kim, 2020, p. 40) and “as a relationship to power” (p. 40) that is mutually
shaped by all interlocking forces of oppression rather than a discreet identity category.

Feminist-of-colour disability studies has four central domains: discourse, state
violence, health/care, and activism (Schalk & Kim, 2020), all of which have guided my
research. Discourse matters. The rhetoric of ability, normality, morality, and worth all
burgeon social hierarchies and result in violence that germinates from this discourse
(Schalk & Kim, 2020). Examining discourses around ability and disability illuminates
how ableism is mutually constituted with racism, sexism, and other forms of oppression
and allows us to map how discourse creates, shapes, justifies, and maintains structures of
power and social oppression (Schalk & Kim, 2020). It also enables us to simultaneously
examine the specificities of race, gender, disability, and other forms of social difference
as we acknowledge their inextricability (Schalk & Kim, 2020). I also intend to add
fatness, systemic anti-fatness, and healthism to these intersections. This lens is productive
for transformative social change because it provides the opportunity to counter discourses
that use the rhetoric of ability to create hierarchies of value and worth (Schalk & Kim,
2020).

Regarding state violence, feminist-of-colour disability studies reminds us that
nation-states sanction the disablement of racialized and impoverished folks through
resource deprivation (Kim, 2017). The state also actively disables people through
criminalization, police brutality, neglecting public infrastructure, gutting public
education, maintaining the school-to-prison pipeline, and removing social safety nets
(Kim, 2017). In Canada, 68% of those killed by the police from 2000 to 2020 were
“experiencing a mental health crisis” (Mukherjee, 2022, p. 142). Additionally, under fatmisia, ableism, and anti-Blackness, fat Black men are paradoxically conceptualized as both inherently disabled and invulnerable to being disabled, casting them as unvictimizable and ultimately allowing for and justifying police violence against them (Mollow, 2017). Moreover, in settler-colonial nations, the logic of elimination, land theft, and degradation “is inextricable from the disablement of Indigenous ontology, bodies, and communities” (Jaffee & John, 2018). There can be no disability justice or meaningful health activism under these conditions. A feminist-of-colour disability studies lens makes clear that health and healthcare are not individual endeavours; decolonization and the abolition of state violence is essential to capacitating wellness for all.

The HAES framework is, of course, concerned with health/care. While disability rights activists have advanced the social model of disability, critiqued the obsession with ‘cure,’ and importantly advocated for less medicalization of disability, most of us need healthcare and we all inherently deserve wellness-capacitating environments. This is especially true for those of us who have historically been and are presently denied quality care by doctors because of our gender, race, or size. It is also true for those of us who are chronically ill, living with pain, and desire care that reduces pain and helps us survive in our current world. A feminist-of-colour analysis is ideal for investigating healthcare and health promotion because it will allow me to account for “cultural and religious perspectives on wellness and healing” (Schalk & Kim, 2020, p. 46) and challenge the ableist underpinnings of so many frameworks of health/care. It will also allow me to mark and challenge eugenic discourses and practices that target low-income, fat,
racialized, Indigenous, Mad, and disabled people without discounting peoples’ needs for care and environments that enable well-being.

Also essential to my project is how feminist-of-colour disability studies takes up activism. Feminist-of-colour disability studies is buttressed by the logic of disability justice. Disability justice is a world-building movement and radical activist practice (Berne, 2020; Lamm, 2015; Sins Invalid, 2016). Disability justice centres multiply marginalized peoples and is anti-normative, abolitionist, and radically transformative (Berne, 2015). This movement has ten principles: intersectionality, leadership of those most impacted, anti-capitalist politic, commitment to cross-movement organizing, recognizing wholeness, sustainability, commitment to cross-disability solidarity, interdependence, collective access, and collective liberation (Berne, 2015). It focuses on working across difference and coalizing to build a more liveable world for all. I also want to add fat liberation as work that this theoretical lens can pull from and support because disability justice and fat liberation both focus on radical systemic and structural change, collectivity and interdependence, body justice, challenging the logic of ableism and healthism, cross-movement solidarity, inherent wholeness and bodymind value, and the abolition of oppressive systems and norms (Freespirit & Aldabaran, 2009; Gordon, 2020; Wong, 2020; Your Fat Friend, 2018).

Ultimately, this theoretical framework is imbued with a methodological approach that enables discourse analysis committed to radical solidarity. Using disability as a generative lens for looking at how interlocking systems of oppression assign value to certain bodyminds allows for meaningful engagement with multiple social justice fields. Using this lens to carry out my CDA is essential for the utility of my project since
feminist-of-colour disability studies paves a path to navigate the complicated terrain of blending health activism, fat liberation, and disability justice. Wellness capacitation and care can centre abolitionist world-building and radical activist practices like disability justice and fat liberation. Rather than organizing around single issues, we can work with and across difference and form generative coalitions to capacitate all bodyminds (Cohen, 1997).

**Conflict of Interest Statement**

To be transparent, I am disclosing that I signed up to be a member of ASDAH in the Fall of 2022. Prior to this, I learned about and practiced HAES in my personal life for years. I worked preliminarily on this project for about a year before signing up as a member. Since ASDAH is the authority on the HAES framework, I wanted to immerse myself more deeply in their articulation of HAES and its future and be kept up to date on their changing priorities to ensure that my understanding and personal practice of HAES continues to be relevant. I viewed their 2022 annual membership meeting on their current goals, priorities and projects but did not participate.

I do not have any personal or professional relationship with any member belonging to or associated with ASDAH, nor have I had any discussions with anyone associated with the organization. Moreover, I have not and will not use any information from the meeting that is not on their website and freely accessible to the public. I am not being paid, endorsed, or supported by ASDAH. However, membership has allowed me to stay more knowledgeable on the organizations’ shifting leadership and priorities and their plans to redraft their core principles and curriculum. Again, this information is publicly
available on their website. Still, as a personal practitioner and partial supporter of HAES, I thought it best to disclose the current state of my association.

**Positionality and Uncomfortable Reflexivity**

Positionality can be defined as “how differences in social position and power shape identities and access in society” (CTLT Indigenous Initiatives, n.d., para. 2). This relationship to power is understood as fluid and inextricably attached to the interlocking systems of oppression. Creswell (2009) notes that qualitative researchers must reflect on our biases and positionality since this information will shape our interpretation of the data. This critical process can be thought of as a practice of reflexivity. Pillow (2003) teaches us that a definition of reflexivity or a procedure for performing it is hard to pin down, but this practice has been deemed essential in ethnographic and qualitative research where we are representing other people’s lived experiences. Practicing reflexivity demands that we be “critically conscious through personal accounting” (Pillow, 2003, p. 178) of how our social location, access to power, priorities, and experiences shape our research. This is particularly important in feminist and social-justice focused research where researchers aim for our research to be empowering, equity-focused, and useful for social transformation. I am a white, cis-gendered, queer, mid-fat, neurodivergent, and disabled woman who lives on the unceded and unsurrendered Omàmiwininiwag (Algonquin Anishinabeg) territory. I grew up middle class and have access to a university-level education. Because of my positionality, community network, and education, I am a proponent of disability justice and fat liberation. But, my lived experiences of heterosexism, anti-fatness, healthism, ableism,
sanism, and sexism have been shaped by my whiteness, class privilege and power as a settler.

I cannot perform this project or disseminate it without grounding it in my pain and privilege and their interconnectedness with our world and the research. This section was initially much longer, and I continued to reflect on my position throughout the research and writing process. I have been diagnosed with anxiety, mood, and eating disorders (although I am now learning non-medicalized and psychiatrized ways of understanding this bodymind difference). I have asthma and contract bronchitis multiple times a year. I also have endometriosis, so I am no stranger to pain. There are days that I cannot leave the house or my bed, and there are days that I spend counting down the seconds until I can return to them. My physical and emotional limit is small. I fall apart easily. I require routine and lots of rest, medication, therapy, work-life balance, calm, kindness, and care to thrive. Unfortunately, we do not live in a world that often allows for these conditions.

On top of emotional distress, I experience extreme pain, fatigue, and brain fog because of my endometriosis. Ableism, sanism, healthism, sexism, capitalism, neoliberalism, anti-fatness and subpar healthcare have hurt me, gotten in the way of my happiness and wellness, and galvanized my desire to perform this research. I have a personal stake in marking the violence these systems carry out and imagining new ways of living. I am not a neutral party in this fight. I am not a neutral party in this research.

Although I intend to critique HAES discourse extensively, I am someone who has benefited from exposure to this framework and community. I started becoming distressed by fatmisia and starving, restricting, and working out obsessively at age 13. Since then, I have moved in and out of phases of starvation and food, exercise, and weight
preoccupation for almost my entire life (although I have since experienced relief). I used food (or the restriction of it), exercise, and the aspiration of bodymind ‘perfection’ to seek safety, love, and redress from interpersonal abuse and systemic violence. Anti-fatness, sexism, ableism, healthism, and the people embodying their violence coerced me to seek to be as small and complacent as possible. I have been all sorts of variations of thin and fat in my life, and socially, never have I been safer than when I was very thin (although I acknowledge that this is because I have never been institutionalized against my will). But although I felt safe from and loved by the fatmisic world when I lost weight, in reality, my ED left me dangerously malnourished, fainting frequently, and socially isolated. It added to my emotional distress, anxiety, depression, chronic fatigue, brain fog, and physical pain. I also internalized fatmisia in my quest for safety, and I became complacent in it.

I learned about HAES through my first attempt at ED ‘recovery’ (see chapter three for a critique on this language and the ED recovery narrative). My therapist at the time introduced me to it and gave me resources to throw myself into, and my care philosophy was formed around its tenets. Learning how to eat and move intuitively and joyfully changed my life. I found what felt like freedom, at least from my ‘judgement voice’ and restrictive and moralized diet and exercise practices. As a health sciences undergraduate student, I was ubiquitously taught to watch and balance what I eat carefully and meticulously plan to exercise the ‘right’ amount in the ‘right’ ways. I was taught that fatness causes disease and that fatness is a problem to be prevented and cured at all costs. So, when I would try to ‘recover,’ my paradigm for seeking wellness was toxic and restrictive. HAES was my first introduction to how pervasive systemic anti-
fatness is. The community instructed me to unfollow anyone who perpetuated diet culture or anti-fatness and to follow every HAES account I could find. I set boundaries with everyone in my personal life that I would not tolerate *any* anti-fat or weight loss discourses. I was eating and moving freely and trying hard to unlearn my fear and hatred of fatness. Still, I could never keep it up until I was introduced to a more explicit fat liberation politic and fat crip community. The HAES discourse and community I was immersed in were not enough. I needed more than individual behavioural modification, a carefully curated feed, ‘challenging diet culture,’ and body positivity and neutrality. So, again, how HAES has both liberated me and failed me will undoubtedly shape my vision and priorities within this research. This is both a potential bias and a benefit because I am an informed user of HAES with insider expertise.

Working through my lived experiences of penalization from the systems I am researching is important, and so is reflecting on the systems that privilege me. I have described the pain I have experienced, but I have been able to move through it because of the privileges afforded to me because of my learning ability, my family’s socioeconomic position, my education, my race, and settler subjectivity. I have received enormous amounts of funds through scholarships dependent on ‘academic excellence’ (not to say these funds brought me much above the poverty line, if at all, but I could largely support myself by immersing myself in my learning). I am a white settler and grew up with green space and money to play sports and pursue art. I have never experienced any trauma or violence from police. I can access healthcare free from racial prejudice and violence.
Now, as a mid-fat woman¹, I struggle to find clothes that I like and can almost only shop online. Many seats are uncomfortable or a tight squeeze for me. Sometimes family members and strangers accusingly comment on what or how much I am eating or even snatch it out of my hands ‘for my own good.’ My social media is filled with fatmisic targeted ads. Nevertheless, I can fit in seats and seat belts and access medical equipment that fits me, such as MRI machines and blood pressure cuffs. These are just some of the ways my wellness has benefitted from my privilege.

The access to power that white supremacy and settler colonialism have afforded me has built my ability to navigate my pain and the penalties the world inflicts on me. It has also made me inclined to miss many aspects of systemic violence that I must learn about from outside sources. My work relies on the embodied knowledge of queers, crips, and women-of-colour who have laboured and resisted endlessly to combat white supremacy and its intersections. I will not face comparable backlash for pushing for the kind of change they do. As I collect, analyze, and interpret my data, I will be conscious of knowledge dampened by white supremacy, colonialism, ableism, classism, and systemic anti-fatness and my relationship to them. I will do my utmost to ask useful questions and represent my research subjects’ and chosen theory’s words and priorities as they would, even knowing this is an impossible task. I will attempt to consider the intersecting modes of oppression that shape our social world holistically and comprehensively, and I will seek out knowledge from those most impacted by them. I will revisit and revise this passage as I continue my research and reflect continuously.

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¹ See Linda (2021) for terminology regarding the fat spectrum, or ‘fategories.’ Mid-fat is on the smaller end of the fat spectrum and refers to people who are a US size 20 to 26 or a 2X to 3X. It is not the same as mid-sized, which refers to those on the upper end of straight sizes who are not considered fat by most people.
I have reflected on and shared all this in attempt to create more thoughtful, useful, and ethical research. I will continue to practice reflexivity throughout every step of my project. Researchers must perform a sustained, expansive, and critical engagement with reflexivity and positionality to undertake ethical feminist research (Kohl & McCutcheon, 2015; Liong, 2015). Still, even if I could practice the most sustained and critical version of reflexivity, it would not produce inherently ethical or accurate research. It would not make me innocent or nonproblematic as a researcher. I am not claiming that my research is more reliable, valid, or free from ethical scrutiny because I am practicing reflexivity. Instead, I am practicing what Pillow (2003) calls “uncomfortable reflexivity” (p. 188). This means I aspire to know but situate “this knowing as tenuous” (Pillow, 2003, p. 188) and embrace the unknowable, unfamiliar, and discomforting. This practice calls for accountability and tackling important work, even knowing that we cannot do it ‘right’ (Pillow, 2003).

**Methodology: TikTok Critical Discourse Analysis (CDA)**

Brady and Gingras (2018), Schalk and Kim (2020), and Clare (2022) assert the importance of free and open engagement, misuse, messiness, contradictions, and disarray when conceptualizing embodiment and liberation. I want to embrace this as I interrogate HAES discourse. I am not aiming to frame the HAES framework as ‘good’ or ‘bad.’ Rather, I want to look at the power relations embedded in how HAES is understood, practiced, and disseminated and unpack the implications for disability justice and fat liberation. I am also not embarking on a solo mission to ‘fix’ HAES. Instead, I want to imagine how we can hold ourselves accountable as proponents of this framework and address the harm we perpetuate. I want to dream of a liveable world and co-struggle
toward collective liberation and interdependence. This is why I chose to study the flow of HAES discourse through social media activism, specifically the platform TikTok. Advocating for and disseminating HAES discourse via the internet is a collective community effort that largely sidesteps the limitations of relying on the state for information and aid. It does not require government funding, enables leadership of thousands, provides the opportunity for pacing and sustainability, and allows people to be creative. However, social media is embedded with the same systems of power that exist in the offline world. Not everyone has equal access, and not everyone has epistemic privilege. Online movements and hashtags can be dominated, coopted, and mutated by those with more power and privilege. It is, therefore, a characteristically messy arena for looking at how the HAES framework has been picked up in activist circles. One full of misuse and potentiality.

Since my project addresses relations of power, dominance, and social justice in connection to discourse, I chose to perform a CDA. CDA “aims to understand and address social issues by critically examining what is included or excluded in texts” (S. Cooper et al., 2017, p. 80). The unifying logic of CDA is that dominance occurs via specific social-relational contexts and is, therefore, socially constructed and alterable. The systematic analysis of texts can elucidate how discourses constitute power (Locke, 2004). As such, CDA must be understood as a “political intervention with its own socially transformative agenda” (Locke, 2004, p. 2). It is anchored in the understanding that discourse reflects and creates dominant power relations and is responsible for constructing reality and meaning-making. In other words, the world order is constructed largely through language, but epistemic privilege shapes who is allowed to speak, what
they are able to say, and who is believed. So, intervening against the apparent neutrality of our current world order by marking the power relations involved in discursively creating and maintaining it is necessary to challenge dominance and enact social transformation. In CDA, the analyst takes an explicit sociopolitical stance to examine the “role of discourse in the (reproduction) and challenge of dominance” (van Dijk, 1993, p. 449). As such, for this method, the theory informing the analysis is chosen based on its relevance for realizing a particular social justice-related goal (van Dijk, 1993). Thus, CDA allows me to utilize a feminist-of-colour disability studies lens to investigate the power involved in articulating health promotion, historically rooted in eugenics, as social justice and fat liberation and trace how this discourse can be informed by and get taken up in service of oppressive systems.

Apparent disadvantages of CDA include that it is context specific and subjective, too broad, and does not provide an explicit procedure or method for researchers (Morgan, 2010). However, I am not trying to identify an objective truth. I plan to take a snapshot of a current issue and unpack just a piece of the puzzle. So, the fact that it is context specific and subjective does not resonate as a disadvantage for my research. I will admit to the lack of procedural specificity as something that was daunting for me, but at the same time allowed me to focus on the aspects of my data that I found most relevant to my theoretical lens, political goals, social position, and skills as a researcher.

Due to its popularity and highly collaborative nature, I chose to collect the online discourse from TikTok, a free-to-use video-sharing social media app. The platform allows users to post videos up to three minutes long, which allows for some complexity and nuance within the discourse. Creators can duet (put their video alongside someone else’s)
and stitch (add to) one another’s TikToks, making it highly collaborative. I was also familiar enough with TikTok to understand the past and current trends and decipher inside jokes and meanings. The reach of TikTok is also expansive. More than three billion people have downloaded TikTok, and the app has more than one billion monthly users, making up 20.8% of all internet users (Ruby, 2022). TikTok is owned by a Chinese company called ByteDance, which merged it with a formerly popular platform called Musical.ly (Entrepreneur Staff, 2023). Used commonly for sharing viral dances, comedy, and memes, it also has a mixed history of capacititating clever and far-reaching activism and repressing marginalized people who speak about social justice. For example, Black activists have accused TikTok of suppressing their content (Mccluskey, 2020). The app has also “admitted to suppressing posts from physically disabled, LGBTQ and overweight users as part of what it said was a set of what was intended to be ‘anti-bullying’ policies” (Mccluskey, 2020, para. 9). At the same time, Oluoch (2023) says that youth engage in political action because of TikTok. Activist content is widely disseminated via the app. A search on TikTok shows that the hashtag #BlackLivesMatter has over 35.5 billion views; #feminism has more than 18.4 billion views; #FatLiberation has over 443.2 million views; #DisabilityJustice has over 15.7 million views; #DisabilityRights has more than 112.7 million views; and #intersectionality has more than 151.7 million views. TikTok videos are also often shared on Instagram and other social media, and TikToks are shareable via text messaging and messaging apps, so its content even reaches those who do not use the platform.

Additionally, I was further drawn to TikTok because it allowed me to examine the thoughts, understandings, experiences, and priorities of proponents of HAES in a
relatively unobtrusive way. I did not communicate with or interact with any content creators and instead looked at naturally occurring and publicly available posts. TikTok is unique to other social media sites in that the main content people view is from their “For You Page,’ which is algorithmically curated rather than made up of posts from pages that people follow (TikTok, 2020). This means that content creators do not expect their content to be viewed only by their followers and know that it may show up on the For You Page of anywhere from hundreds to billions of people. TikTok also lets users choose whether to post their content publicly or privately. TikTokers from whom I recorded data published their videos publicly and hashtagged them with the explicit potential to have them widely circulated because when someone searches a tag, all of the most popular videos under that tag are shown. Since I looked at the 100 top results, all of the videos had significant public engagement. Moreover, as I have noted, TikTok is an interactive platform, and people frequently screen-record, duet, and stitch other creators, so if users are making their content public and hashtagging it with popular tags, it is fair to assume that they are prepared for others to react, share, and critique their knowledge creations. Since TikTok does not require an account to search for and view content, the videos are also available to anyone with internet access.

With these advantages of sourcing popular online discourse from TikTok in mind, these creators did not explicitly consent for their discourse to be used in a research context. This is crucial to consider for ethical purposes, given that much of my work examines how these discourses create harm. Since I did not obtain informed consent, I took steps to protect the content creator’s identities as much as possible. I used pseudonyms and do not reveal the specific hashtag under which I obtained the TikToks. I
chose not to include any of the original audiovisual material in my research and instead relied on my transcription and descriptions of it. I also limited physical descriptions of the posters to sociodemographics only. By the time my research is disseminated, it will be almost a year after I found the TikToks, meaning the majority of the videos that I examined are also unlikely to remain at the top of anyone’s search results. If they are at the top, it would be because the video continues to be watched and engaged with by masses of people. Since TikTok is a video-based platform, keyword searches, even of exact quotes, are unlikely to turn up the original videos unless the users have hashtagged their videos extensively with the words people are searching, the keywords are present in the captions or video titles (which I did not pull from), and the video is still popular.

**Methods**

Drawing from my chosen theoretical orientation, I developed three research questions: 1) What positionalities advocate for HAES on TikTok, and how are they speaking about/framing it? 2) What are the potentialities, limitations, and harms of how the HAES framework is popularly articulated on TikTok? 3) How can HAES discourse shift productively by centring a feminist-of-colour disability studies lens? Using a feminist-of-colour disability studies lens, I then performed a CDA to examine how HAES is understood and disseminated by contemporary activists via TikTok, unpack the power relations embedded in this discourse, and make meaning surrounding what the TikToks are doing discursively. The TikToks were sourced on Sept 13th, 2022, via searching a popular HAES-oriented hashtag. To ensure I could maintain access to the data, I screen-recorded the top 100 relevant TikToks under this hashtag. I chose to look at the most popular videos rather than random ones under the hashtag because this sampling method
better captures the power relations embedded in the dissemination of online discourse. After all, my aim is to look at who dominates and controls HAES discourse. TikTok’s search function works such that when searching a hashtag, the videos that created a trend will be shown first, followed by the most popular videos (TikTok, n.d.). To be included in my research, the TikToks had to be in English and communicate HAES ideology/discourse or make explicit links to HAES principles or HAES ideology (ex., IE, IM, anti-diet culture, fat activism, weight-inclusive health etc.). Ten videos I came across in the top posts were not included in the collected data because they did not meet the criteria. Duplicate uploads were also excluded. An unfortunate aspect of hashtags is that sometimes posters will tag their content with an exuberant number of tags, including irrelevant ones (especially if they are popular), in hopes of getting more people to interact with their content, which is likely one reason why there were irrelevant videos under the hashtag.

To perform quantitative data analysis, various characteristics about the people in the videos and posts were recorded. Each of the 100 TikToks were assigned a number and the data from each were put into an Excel spreadsheet with the following columns: video number, length in seconds, type of video, general description/impression of the video, number of likes, number of saves, number of comments, race/ethnicity of poster, size of poster, gender presentation of poster, and additional hashtags present. I used the available visuals from the videos, captions, and hashtags to aid in this categorization. I also searched the posters’ profiles for additional information in their bios, captions, other videos, and comment sections to solidify ambiguities around identity. If the creators had public websites or additional public social media linked in their bios, I also searched
those when necessary. Descriptive statistical analysis was performed on these data via Excel to determine the frequencies of poster positionalities as well as the averages and medians of each engagement metric.

I used the record of additional hashtags on the 100 TikToks for mixed-method CDA. This included a frequency analysis of the additional hashtags. The hashtag “FYP” (ForYouPage) was excluded for relevance. To ensure relevance, the final hashtag CDA only included hashtags with frequencies greater than or equal to four. The hashtags were then qualitatively grouped into three discursive categories (challenging diet culture and providing ED care, body acceptance and body-neutral health (apolitical), and fat liberation (political)). I analyzed these data using Excel to create basic descriptive statistics (frequencies of the individual hashtags and percentages of each group). All of the quantitative results were then computed into tables and graphs using Excel. This analysis was performed to gain a quantitative snapshot of who advocates for HAES and how they categorize or index the paradigm.

A limitation of my quantitative methods is that if the content creators were racialized but presented as ‘white passing’ and did not reference their race within their available public social media, they would be incorrectly coded as white. I was also only able to confidently determine gender presentation as opposed to identity. Moreover, suppose someone privately self-identified as small-fat but appeared potentially straight-sized and did not claim a fat or plus-sized identity. In that case, I may have incorrectly categorized them as straight-sized. I chose to exclude ‘mid-size’ (size 12-14) as a size category since many people have an incorrect definition and I did not find this categorization essential to my project since the category of straight-sized includes these
people. Additionally, I am not working under the assumption that fat folks are the only ones harmed by anti-fatness or able to speak on their experiences of it. I could not fully confirm all of the content creators’ identities through this process, so the positionality categorizations are often my interpretations. I still believe that these interpretations are important to my project and to understanding who is speaking about HAES and how it is disseminated. There are many assumptions involved in social media consumption. When creators post their content publicly on TikTok and hashtag it, they intend for people who do not know or follow them to watch it. These viewers will interpret their identity categories based on what information they are given and have access to. So, my data collection mirrors the assumptive process of regular content consumption. These assumptions shape people’s understanding of the discourse, as they did mine.

Following my quantitative analysis, I transcribed the TikToks and uploaded the transcripts to NVivo. I then reviewed the transcripts for mistakes and errors. Next, I read through the data to get a first impression of the material. Preliminary coding was performed using the work of Creswell (2009) and Saldaña (2016) as guidance. I then completed another round of coding and developed eight main categories. Finally, I reviewed the data again and determined the overarching themes with the plan that these might change as I continued to unravel the data. After four phases of rigorous coding, I determined four main descriptive themes for the discourse present in the TikToks, which were: framing HAES as an ED ‘recovery’ tool, space, and community; countering systems of oppression; perpetuation of systems of oppression; and self-love and fat joy. I then utilized these broad descriptive themes to think about what the 100 TikToks were doing discursively. This helped me to articulate that HAES discourse provides some
forms of liberation and perpetuates interlocking systems of oppression and eugenic projects. I framed these two processes as “healing and world-building” (again, see chapter three for my description of a crip understanding of healing) and “domination, mutation, and cooptation.” These themes then allowed me to further my CDA of the power relations shaping and being shaped by the discourse and their implications for HAES and fat liberation, which eventually formed my main arguments and conclusion. In accordance with Creswell (2009), I used several strategies to increase the validity of my findings. I incorporated perspectives from as many videos as possible and took my entire dataset into account when coding and determining themes. As much as possible, I used rich and thick descriptions to present the data by summarizing using the participants’ own words and including direct quotes as evidence.

Conclusion

In this chapter, I have summarized the problem of anti-fatness in health promotion, explained the scope of its harm, explained HAES’ purpose as an intervention to this problem, summarized current scholarship on HAES, pointed out gaps in the literature, presented my theoretical framework, grounded my theorizing in my positionality, made clear my methodology, and presented my methods, including my research questions. This chapter is intended to give readers the necessary background to fully and critically engage with my analysis chapters (chapters two and three). Once again invoking Pillow’s (2003) idea of uncomfortable reflexivity, I encourage anyone reading this thesis to join me in challenging their positionality and assumed knowledges continuously while seeking to make meaning from and with my findings.
Chapter Two: Dominated, Coopted, and Mutated (How HAES Discourse is Mutating Fat Liberation’s Purpose into Eugenic Health Promotion)

In this chapter, I have two primary purposes. The first is to demonstrate how the current definition of healthism is too narrow and fails to acknowledge the centrality of anti-Black racism, white supremacy, colonialism, and ableism in healthist ideology, discourse, and practices. Because of this current gap, I propose a new feminist-of-colour disability studies-oriented definition of healthism, which I coin as co-healthism to mark its roots in co-constituting oppressive systems that mutually reinforce one another in weaponizing health as a prerequisite to worth. My second objective is to argue that HAES supporters on TikTok have coopted fat liberation’s world-building goal through and with co-healthism to mutate it into health promotion, ultimately furthering co-healthist eugenic projects under the guise of beneficial and necessary social transformation. I will ultimately show that this mutation serves those whose embodiment can be understood as ‘normal,’ or ideal, at the expense of those whose bodies will always be coded as ‘deviant’ under eugenic ideology, such as BIPOC, super/infinifat people, disabled people, Mad people, and chronically ill people.

I outline how eugenic health promotion has always been framed as for the good of society. However, due to the blurry aggregation of health enhancement and social justice in HAES discourse, this framing can evolve in a world that largely condemns the overt eradication of non-normative bodyminds. Because HAES discourse presents the framework as quality and benevolent health promotion and a solution to anti-fatness, HAES discourse is not only able to frame eugenic health promotion as for the good of society but also frame it as fat liberation. This allows for the cooptation of fat liberation
ideology and a mutation of its world-building goal into health promotion. The mutation of fat liberation’s collective and coalitional politic is made possible through and with discursive violence propagated by co-healthist systems and structures, and it also simultaneously reinforces the discursive power of co-healthism to materially shape people’s access to power under the interlocking systems of oppression. With these objectives in mind, the first part of this chapter presents the quantitative and mixed-method data for this study using tables and charts. Immediately following, I present the qualitative analysis of what HAES is doing discursively. These sections examine the limitations and harms of how the current HAES framework is popularly brought to life on TikTok. I then conclude with the implications of this domination to ultimately segue into my third and final analysis chapter by calling for a severance of co-healthism and a centring of disability justice in HAES practices and politics.

Quantitative Results and Analysis: Engagement Metrics and Positionalities

Table 1

<table>
<thead>
<tr>
<th></th>
<th>Likes</th>
<th>Comments</th>
<th>Saves</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean</strong></td>
<td>33 392</td>
<td>539</td>
<td>1382</td>
</tr>
<tr>
<td><strong>Median</strong></td>
<td>8635</td>
<td>192</td>
<td>187</td>
</tr>
</tbody>
</table>

Table 2

<table>
<thead>
<tr>
<th>Positionality Categories</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Size</strong></td>
<td></td>
</tr>
<tr>
<td>Fat</td>
<td>58</td>
</tr>
<tr>
<td>Straight Sized</td>
<td>42</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>85</td>
</tr>
<tr>
<td>Black</td>
<td>3</td>
</tr>
<tr>
<td>Central/ South Asian</td>
<td>3</td>
</tr>
</tbody>
</table>
Non-white Not Otherwise Specified  5
Indigenous (Wayúu)  1

**Gender Presentation**
Feminine and Female  99
Androgynous Presenting  1

**Figure 1**

*Positionality Metrics for Size*

![Pie chart showing size metrics](chart1)

**Figure 2**

*Positionality Metrics for Race/ Ethnicity*

![Pie chart showing race/ethnicity metrics](chart2)
Overall, the TikToks had significant levels of engagement, with an average of 33,392 likes, 539 comments, and 1,382 saves. The respective medians were 8,635, 192, and 187. I interpreted the overwhelming majority of the content creators as white or white-passing and female-presenting. All the female-presenting TikTokers also presented as feminine. These findings support previous assertions that HAES has been dominated by white women (ASDAH, n.d.-b). It also supports my assertion that HAES discourse is shaped by white feminism, which I elaborate on below. Interestingly, 58% of the TikTokers were fat, while 42% were straight-sized. To be clear, I do not highlight this finding to exclude thin or straight-sized people from fat activism, although reflexivity about one's positionality and relationship to power is essential in any activist movement. Anti-fatness harms fat people, especially superfat and infinifat people, in particular ways. This shows up via violence, exclusion, and microaggressions that straight-sized people never experience. And, with these essential specific concerns in mind, anti-fatness, thin valorization, and diet culture harm thin people too. Thin people can internalize anti-fatness to the point that it controls their lives and causes distress. With this important caveat in mind, the significant portion of straight-sized practitioners is an important
finding because it shows that many of those who benefit from and advocate for HAES are straight-sized and that this positionality is the source of a significant amount of the discourse.

**Mixed-Method Hashtag Results and Analysis**

**Table 3**

*Additional Hashtag Frequencies*

<table>
<thead>
<tr>
<th>Hashtag</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>#BodyPositivity</td>
<td>29</td>
</tr>
<tr>
<td>#AntiDiet</td>
<td>18</td>
</tr>
<tr>
<td>#IntuitiveEating</td>
<td>17</td>
</tr>
<tr>
<td>#FatLiberation</td>
<td>15</td>
</tr>
<tr>
<td>#FatPositive</td>
<td>14</td>
</tr>
<tr>
<td>#PlusSize</td>
<td>14</td>
</tr>
<tr>
<td>#Fat</td>
<td>14</td>
</tr>
<tr>
<td>#DietCulture</td>
<td>12</td>
</tr>
<tr>
<td>#BodyNeutrality</td>
<td>11</td>
</tr>
<tr>
<td>#Fatphobia</td>
<td>10</td>
</tr>
<tr>
<td>#EDRecovery</td>
<td>8</td>
</tr>
<tr>
<td>#BodyAcceptance</td>
<td>8</td>
</tr>
<tr>
<td>#BodyPositive</td>
<td>8</td>
</tr>
<tr>
<td>#WeightLoss</td>
<td>7</td>
</tr>
<tr>
<td>#SelfLove</td>
<td>7</td>
</tr>
<tr>
<td>#FoodFreedom</td>
<td>6</td>
</tr>
<tr>
<td>#NormalizeNormalBodies</td>
<td>6</td>
</tr>
<tr>
<td>#FatAcceptance</td>
<td>6</td>
</tr>
<tr>
<td>#AllBodiesAreGoodBodies</td>
<td>5</td>
</tr>
<tr>
<td>#PlusSizeTikTok</td>
<td>5</td>
</tr>
<tr>
<td>#FatPositivity</td>
<td>5</td>
</tr>
<tr>
<td>#AntiFatBias</td>
<td>4</td>
</tr>
<tr>
<td>#CurvyTikTok</td>
<td>4</td>
</tr>
<tr>
<td>#Recovery</td>
<td>4</td>
</tr>
<tr>
<td>#AntiDietCulture</td>
<td>4</td>
</tr>
<tr>
<td>#Health</td>
<td>4</td>
</tr>
<tr>
<td>#PlusSizeEdition</td>
<td>4</td>
</tr>
<tr>
<td>#HealthyLiving</td>
<td>4</td>
</tr>
</tbody>
</table>
Content creators use hashtags to index their content. However, hashtags are also equivalent to a marketing technique. Posters can tag their videos with trending hashtags that may correspond with more views and engagement from communities or niches they are involved in or want to reach. So, hashtags provide a unique opportunity to see how people supporting and using HAES understand the framework, what language they think is best to promote it, what they correlate it with, and the purpose they think it is serving (i.e., providing care for people who identify with disordered eating, propagating body neutrality, or aiding fat liberation). After performing a frequency analysis of hashtags that were present at least four times, I grouped them to unpack how the content creators are framing HAES. I excluded #WeightLoss as an outlier in the grouping because its presence denotes many things depending on the discourse it is paired with.
The first group is ‘challenging diet culture and providing ED care,’ which comprised 28.0% of the total hashtags. I engage with this discourse in chapter three. The second group is ‘Body acceptance and body neutral health (apolitical),’ which accounts for 42.3% of the discourse. This group of hashtags avoids fat pride language, skirts around the word ‘fat,’ appeals to normalization, and individualizes internalized anti-fatness and resistance. Fat studies scholars and fat liberation activists are critical of body positivity discourse for its apolitical messaging, watering-down of fat liberation tenets, and individualization of collective and systemic issues (Cooper, 2016; Gordon, 2020; D. Harrison, 2021). Like framing HAES as body positivity, articulating fat embodiment as ‘plus size’ or ‘curvy’ can obscure systems-level analyses and work to move fatness into a depoliticized category of respectability, morality, and obedience. This is also true regarding the presence of ‘health’ and even more so ‘healthy living.’ People want to feel good, and there is nothing wrong with that. Learning to love and care for oneself can be a radical act in a world that wants us to hate ourselves. The problem arises when we stop here. This grouping shows HAES practitioners correlate HAES with apolitical body acceptance and health movements.

The final group is ‘Fat liberation (political),’ which amounts to 29.7% of HAES’ indexing. As mentioned in chapter one, The HAES framework explicitly claims a fat liberation politic rooted in eliminating oppression. Its overseers are also overtly anti-healthist and against framing health as an individual responsibility or a moral imperative. This discourse aligns with fat liberation because it is concerned with radical transformative social change, interdependence and collectivity, body justice, and the abolition of oppressive systems, norms, and ideologies. The prevalence and variety of
tags in this third group suggest that practitioners of HAES understand that it is supposed to be radical and/or want to index it as such. Some of the discourse that I analyze is in line with this group. Most are not. This has led me to focus my theorizing in this chapter on the power involved in claiming fat liberation ideology.

**Healthism in HAES**

My analysis of the data demonstrates that HAES supporters frequently engage in discourse that individualizes and moralizes health status and behaviour, which embodies what is classically understood as healthism. However, their discourse also supports eugenic projects by inserting what they articulate as ‘healthy’ fat bodies into the category of ‘normal’ (ideal) embodiment, obscures the white supremacist state violence responsible for pathologizing, disabling, and debilitating people, and reinforces colonial domination by cementing HAES in Western biomedicine and framing it as “the way” to health and body liberation. These phenomena firmly shape my understanding of what HAES discourse is *doing* and are all examples of how the HAES content creators understand, define, articulate, and support ‘health,’ ‘healthy’ living, ‘health’ activism, and ‘health’ promotion and enhancement. These patterns work to reinforce the power of interlocking systems of oppression to define health as normal embodiment and ideal subjecthood; require health for valued subjecthood; prescribe ‘health promotion’ as crucial social transformation while also framing it as the moral and biological betterment of society; and preclude systems-level analyses that would benefit marginalized people’s wellness. While these processes rely on and invoke the problematic availing of ‘good health’ for the benefit of society, they do not all fit into the current definition of healthism.
Healthism was defined by Crawford (1980) as increasing “preoccupation with personal health as a primary- often *the* primary- focus for the definition and achievement of well-being” (p. 386, emphasis in original) paired with the ideology that it is an “individual moral failing” (p. 390) if one does not engage in health-promoting behaviours. Healthism continues to be understood as an ideology that frames health as a moral imperative for every individual to strive for via ‘proper’ health behaviours. The neoliberal logic embedded in healthism obscures the political, social, and environmental conditions that affect people’s wellness by framing health as individually determined. This individualization obscures the state violence responsible for harming marginalized people’s wellness and shifts the burden of care away from the state or collective and onto individuals, which is essential to maintaining neoliberal governance that does not fund health/care for its subjects (C. Cooper, 2016).

HAES has already been extensively critiqued for perpetuating healthism (Gibson, 2022; Mackert & Schorb, 2022; Welsh, 2011) because it fails to destabilize health as a neoliberal ideal, individual moral imperative, and aspirational identity and embodiment. My data showing HAES content creators’ individualization of health and the assertion that being healthy makes them morally superior supports the aforementioned scholarship that accuses HAES of healthism. It also adds to this scholarship by showing that many HAES advocate’s framings of HAES and definitions of health are rooted in what is currently understood as healthism. Brittney, a white fat female-presenting person, says about HAES, “so instead of using weight as a barometer for success, we focus on health behaviours” (emphasis added). In the same vein, Mckayla, a white fat female-presenting health professional, says the three *best* things someone can do to improve their health are:
to exercise more, to eat more nutritiously, and to lower their stress levels. And ya, a combination of those three things—or even one of those things or two of those things—can cause weight loss! But the weight loss is a by-product of those things; it's like a side effect. Weight loss should not be the focus of your health journey cuz you can lose weight and still be unhealthy. Health at Every Size folks, get into it! (emphasis added)

Weight loss “should not” be the focus; the focus should be on pursuing health through exercising more, eating more nutritionally, and being less stressed. In an even more explicit moralization of health, Jennifer, a white fat female-presenting person, maintains that ‘good health’ (presented as the ability to run a 10K) is what matters for (self) worth, not weight:

Please understand, if this describes you, if I am your cautionary tale, don’t let it be because of my weight. Let my life encourage you to start separating your self-worth and measures of your health from the number on the scale. I’m sorry if you hate yourself, but don’t take that shit out on me. And if you wanna take a walk and talk about it, I’m 10K ready! And that’s on health! (emphasis added)

Catherine, a white fat female-presenting person, also insinuates that being physically strong makes them better than people who do not lift or are physically weak when they say, “I go to the gym. And I leg press over 500 pounds. Try doing that when you’re like 100 pounds and have absolutely no muscle mass [laughs].”

Of course, not every supporter of HAES individualizes and moralizes health status, but healthism dominates most of the discourse in my data. Twenty-seven of the TikToks focused on IE and/or IM (individual health behaviours). None discuss who has
access to these practices or the systemic violence that shapes this access. These data show that these individual behaviours are firmly embedded in HAES advocates’ understanding of health and challenging anti-fatness. Overall, it is clear that many HAES supporters’ understandings of health and fat activism are tied up in what is traditionally understood as healthism. However, as I have mentioned, this definition does not capture the entirety of how health is deployed as a weapon against bodies that get marked as ‘unhealthy’ within the data.

**From Healthism to Co-healthism: Centring Ableism, Anti-Blackness, White Supremacy, and Colonialism in Our Analyses**

As I have elucidated, the invocation and prescription of ‘good health’ in the data presented thus far (evidently framed as the ability to lift heavy, run 10Ks, eat intuitively, exercise joyfully etc.) is healthist in the classic way that healthism is understood. It is also indicative of more recent work that points out how healthism is entwined with ableism and anti-fatness. Gordon (2020) notes that it is “closely linked to both anti-fatness and ableism” (p. 10), while C. Cooper (2016) adds that healthism’s health imperative is not only about staying free from illness but is “about presenting yourself to the world as glowingly well, athletic, able-bodied and full of vitality” (p. 184). Similarly, Chrisler and Barney (2017) note that healthism buttresses anti-fat bias in medicine and the “medicalization of body size” (p. 41) because healthism prescribes that everyone can and should work to attain a ‘healthy’ body and, under the WCHP, fatness is correlated with poor health. This medicalization of non-normative bodies corresponds with the medical model of disability, which frames disability as an individual pathology that must be erased via cure rather than a sociocultural experience and identity (Critical Disability
Studies Collective, 2023). My analysis expands upon current literature by arguing that along with ableism and anti-fatness, anti-Blackness, white supremacy, and colonialism are also inextricably entwined with the definition of, and the demand for, ‘good health’ and health promotion. They are thus key to making clear how healthism penalizes certain bodies by marking them for disablement and eradication while capacitating others with social privilege. The definition of ‘good health’ is not only exclusionary to chronically ill, Mad, fat, and disabled communities but, importantly, also has its roots in the origins of anti-Blackness and the creation of race.

D. Harrison (2021) expands Strings’ (2019) argument that anti-fatness is not about health and is actually about legitimizing anti-Blackness to say that it is about health (although not about capacitating well-being). D. Harrison (2021) asserts that the exclusionary label of ‘healthy’ was created to serve as the antithesis of ‘Black’ to justify anti-Blackness and enslavement. They note that in the 1800s, white scientists, anthropologists, and doctors invented ‘illnesses’ to pathologize enslaved Black people’s desires for freedom and establish that Black folks had “no need for, or right to, safety or wellness” (p. 34). These white men furthered this practice by also inventing illnesses to describe a supposed inevitable weakness and laziness that would arise in Black folks if they were not enslaved (D. Harrison, 2021). Thus, according to D. Harrison (2021), ‘health’ is not merely something that has been taken from Black people but is actually a category that Black folks have never had access to. They say that the pathologization of fatness and equation of fatness with Blackness arose as an additional way to continue to prevent Black bodies’ access to ‘health’ and corresponding access to safety and wellness. They make clear that for people to be ‘healthy,’ they must “feel mentally secure,
physically safe, and socially well” (p. 33), which cannot occur in a world saturated by anti-Blackness and anti-fatness:

For anti-Blackness and anti-fatness to be legitimate subjugating and objectifying structures, their existence had to be predicated on a Thing unobtainable by Black fat subjects. That Thing is health. In other words, to legitimize race, sex, and class statuses, health had a job to do. That job was to ensure that the Black—which is, too, the fat—was always fixed to be something that Black fat subjects could not be. (p. 36)

So, like fatness, the categories of ‘health’ and ‘healthy’ are rooted in the subjugation of Black bodies. Correspondingly, I put forward that health ism must also be rooted in and co-constituted with anti-fatness and anti-Blackness. Importantly, it is also servicing the continuation of white supremacy by disciplining white people into pursuing health to maintain their higher status and access to whiteness:

Fatness and health, like race, are also double agents. They are all used to tell Black fat people who and what they are, but they are also used to tell white people who they should not want to become. When they fail to model that, it can be deadly for them too. Not in the same way as it is for the Black, but deadly as a result of unintentionally aligning oneself with what exists as the obverse of whiteness. (D. Harrison, 2021, p. 37)

Western eugenicist race science was popularized and disseminated to further this job of establishing ‘health’ as whiteness and thinness. It also worked to establish it as able-bodymindedness. Adolphe Quetelet’s work, a statistician from the 19th century, was used to relocate the meaning of a ‘norm’ from a statistical average to something that
signifies the ‘right’ way to be (Davis, 2019). Sir Francis Galton, a noted eugenicist credited with coining ‘eugenics,’ used this ideology and statistical method to create an ‘ideal’ body that worked as the aspirational opposite to the ‘deviant’ body (Davis, 2019). Therefore, the bodymind category or classification of ‘normal’ is not ‘average.’ It is a prescriptive and disciplinary ideal that assigns value to hegemonic bodies and marks bodies that deviate from this ideal for subjugation and eradication. This proliferation of the aspirational ‘norm’ (or ideal body) thus underpins the continuation of eugenic projects. Galton described eugenics as “the study of the agencies under social control that may improve or repair the racial qualities of the future generations, either physically or mentally” (McLaren, 2014, p. 15). Mitchell and Snyder (2003) define it as “the science of racial purification and the elimination of human ‘defects’” (p. 844) and mark this practice as “the site where racial and biological inferiority dovetailed” (p. 844, emphasis added).

In other words, the goal of eugenic projects is to enhance society by eliminating the ‘deviant’ and proliferating the ‘norm’ (ideal), and these categories are defined by white supremacist ableism. Mitchell and Snyder (2003) show how disability and race are mutually constituted as both rely on the categorization of apparent biological inferiority or defectiveness to dehumanize people and justify their domination, exclusion, institutionalization, sterilization, and eradication. They say that:

one of the characteristics that connected African, Native American and Jew together in the eugenics trajectory of racial particularity was a shared incapacity to assimilate. While the biological qualities attributed to each racial group differed, the ‘incapacity’ to integrate conjoined with historical associations of impurity (or excessive purity) and barbarity marked all three racial groups as
excessively deviant. A racial aberrancy that came to be consistently characterised as *biological* (Mitchell & Snyder, 2003, emphasis added)

The apparent social ‘good’ of enhancing the ‘health’ of society by ‘scientifically’ perfecting some bodies while eliminating others has always been used to justify the domination and erasure of those deemed biologically, and thus morally, inferior. The category of health is thus inextricable from eugenic conceptions of ‘normal’ (morally and biologically ideal) bodies, which are defined by proximity to hegemonic embodiment (whiteness, thinness, able-bodilymindedness). Therefore, by extension, I assert that healthism is not only rooted in anti-Blackness, anti-fatness, and white supremacy but also ableism and eugenic colonial science, as they are co-constituted and inextricable from one another.

This brings me to coining co-healthism. Healthism disciplines people into ‘proper’ health behaviours and moralizes and individualizes health through neoliberal governance and cultures. However, the purpose and violence of this prescription and moralization cannot be fully understood without centring the ideologies, histories, contexts, and power of ableism, anti-Blackness, anti-fatness, white supremacy and colonialism in our analyses. Similar (but distinct) to how, according to Schalk and Kim (2020), disability can be used as a method or lens for elucidating how “ableism, heteropatriarchy, white supremacy, and capitalist violence” (pp. 37-38) intersect and mutually reinforce one another to assign varying value to particular bodyminds,” I further that *health* can be expanded from an embodiment (or resource or capacity if we use ASDAH’s definition presented in chapter one) to a lens and method capable of unpacking how anti-Blackness, white supremacy, anti-fatness, ableism, colonialism, and
neoliberalism mutually reinforce one another to require normal embodiment as a
prerequisite to worth and valued subjecthood. This method can also elucidate how “health
promotion” via the perfecting of some bodies and elimination of others is positioned as
benevolent and essential to society’s moral and biological betterment. I believe that the
concept of co-healthism allows for this shift.

My definition of co-healthism is limited to the scope of my research project, so
there are undoubtedly many more layers that could be made clear given the wide range
and co-constitution of systems of oppression. With this acknowledgment of its room to
grow in mind, I am defining it as a web of oppressive systems where anti-Blackness,
white supremacy, anti-fatness, ableism, colonialism, and neoliberalism mutually reinforce
one another to require ‘health’ as an individual imperative and prerequisite to valued
subjecthood; and prescribe “health promotion” via the perfection of some bodies and
elimination of others; both of which are positioned as essential to the moral and
biological betterment of society. Through co-healthism, health is understood as ‘normal’
(ideal) embodiment that can or should be strived for or is achieved through ‘good’ or
‘proper’ behaviour and Western biomedical intervention. Co-healthism propagates
eugenic projects (called health promotion) and is both buttressed by and buttresses
interlocking systems of oppression to preclude systems-level analyses that would benefit
marginalized people’s wellness and healing and challenge the status quo. It also actively
harms people’s wellness and effectively disables and kills marginalized populations, with
those furthest from ideal embodiment facing disproportionate penalties. It is paradoxical
because although co-healthism requires everyone to pursue ‘health’ in an attempt to find
inclusion and safety within the state (and the presentation of ‘health’ does provide limited
safety and access to power) because the category of ‘health’ is defined based on one’s
proximity to normal (ideal) embodiment (whiteness, thinness, able-bodiedmindedness),
non-normative bodies will always be coded as unhealthy. This ubiquitous presence of
“unhealthiness” is then used to reinforce and justify co-healthist domination and control
by presenting it as a benevolent world-building project.

Now that I have defined co-healthism, I will outline how the data elucidate how it
works and what it is doing. I will then further my argument that co-healthism allows
HAES discourse to mutate fat liberation's world-building purpose into health
enhancement, which is then masked as humanitarian social transformation. HAES
supporters engage in this co-healthist discursive mutation by inserting what they
articulate as 'healthy' fat bodies into the category of 'normal' (ideal) embodiment,
obscuring anti-Blackness and white supremacy's roles in shaping people's well-being, and
using colonial logic to frame Western biomedicine as "the way" to health and body
liberation.

“I'm Fat but I'm Healthy:” Co-healthist Ableism in HAES Discourse

HAES content creators participate in co-healthism via the proliferation of ableist
discourse that supports eugenic projects through a pervasive attempt to link (some forms
of) fatness with healthy (normal) embodiment. In line with feminist-of-colour disability
studies, ableism can be defined as:

A system that places value on people’s bodies and minds based on societally
constructed ideas of normalcy, intelligence, excellence, and productivity. These
constructed ideas are deeply rooted in anti-Blackness, eugenics, colonialism, and
capitalism. This form of systemic oppression leads to people and society
determining who is valuable and worthy based on a person’s appearance and/or their ability to satisfactorily (re)produce, excel and ‘behave.’ You do not have to be disabled to experience ableism. (Lewis, 2020, para. 4)

Much of the discourse from the previous section on healthism shows how ableism infiltrates HAES by assigning higher worth to physically strong, fit, and enduring bodies. I want to further this discussion by examining the HAES TikTokers’ more explicit links of fatness to ‘good’ health and normal (biologically and morally ideal) embodiment. As discussed, under co-healthism, the category of ‘good’ health is based on one’s proximity to normal (ideal) embodiment (whiteness, thinness, and able-bodiedness). Rather than address the violence that the category of ‘health’ allows for, HAES supporters in the data most often seek liberation by claiming the power and safety that comes from being seen as healthy. They thus unintentionally validate eugenic projects of bettering society via the elimination of ‘poor health,’ or bodies marked as deviant and thus ‘unhealthy’ while carrying out their fat activism. This ‘liberatory’ work supports the prescription of health promotion via the perfection of some bodies and the elimination of others.

Kylie, a white thin female-presenting person, uses a greenscreen effect to show four people of varying body sizes smiling and laughing while grouped together:

Listen up if you’re loving the body positivity trend but are also a bit confused as to whether all of these beautiful shapes and sizes are truly healthy. So, who is healthier? If you asked me this last year, I would have automatically said [the thin person], when really, we cannot tell by looking at someone. [The fat one] and [the thin one] can be equally as healthy. Just because [the thin one] is leaner does NOT mean she is healthier. Weight is not associated with health! (emphasis added)
The question that is posed is, “is body positivity healthy?” By body positivity, this creator presumably means being fat. The answer: yes! *Fat does not mean unhealthy!* Insinuated here is that fatness can be loved and allowed to exist because “weight is not associated with health” (although really, this should say causally correlated).

Hope, a white fat female-presenting person, also believes that she should not be targeted for eradication because she is ‘healthy’ and is outraged at the discrimination she experienced as a ‘healthy’ fat person. Her TikTok is a simulated re-creation of a past conversation:

Healthcare Professional: Your BMI is high for your height; maybe you would have done better with the cardiac stress test if you weighed less.

Hope: I work out three to five days a week, and cardio is included every time. I have a heart condition, that’s probably why my arrhythmia started acting up during the test.

Healthcare Professional: [Text appears that says “in their head”] she must be lying; there’s no way she works out that much and is still overweight.

The simulated conversation ends, and the TikTok switches to a close-up shot of Hope saying, “you can work out regularly and still be fat; thank you!” She then smiles and gives a thumbs-up. The discourse here makes it clear that she believes she should be exempt from anti-fat microaggressions because she works out regularly. Yes, she is fat and has a heart condition, but she can still embody health via executing health behaviours, exuding vitality, and assimilating into bodily normalcy through performing able-bodilymindedness.
Jordan, a white fat female-presenting person, uses the same reasoning. After sharing a story of obstetric coercion where their birthing autonomy was disrespected, they say: “I’m fat but I’m healthy” (emphasis added). They do not appear upset that their care provider performed unwanted medical intervention justified by anti-fatness and intersecting modes of oppression. They are mad because they are healthy and should therefore be listened to and given the respect, value, and safety that come with relative proximity to normal (ideal) embodiment. Of course, healthcare professionals consider the risk of complications when recommending treatment (although that should not trump bodily autonomy), but the language here is not centred around risk or lack of risk. It is centred around health.

Amelia, a white thin female-presenting HAES professional, quoting Dr. Lindo Bacon’s book, *Health at Every Size*, uses explicitly eugenicist language that bases their critique of anti-fatness on the fact that fat people can sometimes be included in biological normalcy and co-healthist articulations of health:

> While I am not arguing that we encourage weight gain in order to improve health or that body weight is irrelevant to health, it is clear that the threat posed by our weight and the benefits of weight loss have been misinterpreted and exaggerated. At both extremes, high and low, body weight adversely affects health. *But the vast majority of Americans fall closer to the middle of the body fat bell curve, where weight is little more than a benign marker of an individual’s genetic predisposition to carry it […]* Though a heavy weight may be the result of imprudent lifestyle habits or underlying disease in some individuals, there are also many large people who eat sensibly, exercise regularly, and have *excellent health*
readings. And many thin people who don’t. Regardless, a low weight or healthy lifestyle habits should not be a requisite for respect […] ‘Normal’ weight is neither normal, most people exceed it, nor ideal in terms of health. (emphasis added)

Amelia, through Bacon, is shifting the bell curve to include small and mid-fat people in the norm because, for us, weight is “benign.” The language of benign or non-cancerous makes it clear that by invoking the “norm,” they are not merely talking about an average. They are talking about a biologically and morally ideal subject. They go on to say that many (small/mid) fat people eat healthy, exercise, and have “excellent health readings” (emphasis added). They are redefining whose bodies count as normal because the old version was not actually biologically “ideal.” For Amelia, through Bacon, anti-fatness needs to be challenged with ‘better’ health promotion because, in its current iteration, it is not properly serving the biological enhancement of society. Mentioning that poor health should not justify disrespect does not erase the lack of consideration for those whose embodiment cannot be classified as ‘benign’ under co-healthism.

In sum, what about the unhealthy? What about those who will never embody the ideal? Arguing that fatness is normal and that fat folks can also be healthy can combat some forms of anti-fatness. However, Meleo-Erwin (2012) asserts that attempting to include fatness under the label of normal, “particularly through attempts to link certain forms of fatness and health, is a losing battle” (p. 389). This strategy relies on some privileged fat folks assimilating into the power that comes with being perceived as having normal embodiment, leaving bodies still coded as deviant (specifically larger fat people) behind (Meleo-Erwin, 2012). Some fat folk’s behaviour can be more directly linked with
their actions, meaning under this strategy, they are still pathologized and unable to assimilate into an ideal embodiment and subjection (Meleo-Erwin, 2012, p. 393).

Certain fat people assimilating into the power that comes with embodiment conceptualized as normal (ideal) fails those unable or unwilling to assimilate. It is ineffective at creating meaningful social change because assimilation depends on people being willing to maintain the status quo. HAES supporters asserting that ‘healthy’ fat people should not be discriminated against stems from, and supports, co-healthist ideology that defines ‘health’ as normal (ideal) embodiment, good behaviour, and able-bodymindedness and articulates social justice as respecting ‘healthy’ fat people that exude able-bodymindedness and excellence. This framing furthers the penalization of ‘unhealthy’ bodies and allows fat liberation’s world-building goal to be mutated into eugenic health promotion.

Once again, I want to clarify that people can pursue enjoyment, comfort, behaviours that make them feel mentally and physically sound, and improved biological and emotional health markers without reinforcing co-healthism. I do not intend to suggest that people should stop pursuing these things. I practice my own version of IE and IM and have relieved much pain and brought much joy to my life through them. Nevertheless, by prescribing health enhancement and reducing it to individual behavioural modification, framing health as normal (ideal) embodiment, framing healthiness as morally superior, linking certain forms of fatness to health and bodily normalcy, and basing fat people’s worthiness and deservedness of liberation on said health and normalcy, HAES practitioners are furthering the reach of co-healthism to carry
out and justify ableism and eugenic projects and wrongly frame health promotion as fat liberation.

“I’m Not Here to Speak on That:” Co-healthist White Supremacist Discursive Violence and White Feminism in HAES Discourse

I have just discussed how HAES advocates participate in maintaining eugenic discourse that frames ‘healthy’ fats as morally and biologically superior, defines health as ‘normal’ (ideal) embodiment and ‘proper’ behaviour, and mutates fat liberation’s purpose into health promotion (the proliferation of ‘normal’ (ideal) bodies and the eradication of deviant bodies). Another key element to co-healthism’s oppressive project is its propagation of discursive violence that obscures anti-Blackness and white supremacy’s roles in shaping people’s well-being. Discursive violence is “masking or effacing other forms of violence and/or productive of negative valence […] that colludes with other manifestations of violence generally” (Holling, 2019). The HAES supporters on TikTok fail to challenge the white supremacist state violence that shapes people’s capacities, wellness, and access to power. Moreover, rather than acknowledging that anti-fatness is rooted in white supremacy, anti-Blackness, and settler colonialism, they repeatedly articulate its roots in patriarchy alone. This discourse precludes systems-level analysis that would actually benefit racialized people’s well-being. It also maintains the violent status quo while framing itself as benevolent, leaving room for co-healthist articulations of world-building within fat activist, feminist, and health activist discourse. Therefore, this discursive violence, like the claim to fat normalcy, perpetuates white supremacist definitions of ‘health’ and supports the mutation of fat liberation’s purpose into co-healthist health promotion. This exclusive focus on patriarchy can be described as white
feminism, which claims to work to liberate all women but only considers the views and needs of white women (Moon & Holling, 2020). Moon and Holling (2020) argue that: in the interest of improving white women’s positionality within a white power structure, (white) feminism ideologically grounds itself in a gendered victimology that masks its participation and functionality in white supremacy. By erasing women of color, positioning women as victims of white male hegemony, and failing to hold white women accountable for the production and reproduction of white supremacy, (white) feminism manifests its allegiance to whiteness and in doing so commits ‘discursive violence.’ (pp. 253-255)

The HAES discourse certainly fails to hold white women accountable for our role in (re)producing white supremacy. Instead, it focuses on how white women and femmes are victimized by patriarchal diet culture and ignores how white supremacy shapes health and experiences of anti-fatness and diet culture. There were only three mentions of white supremacy or racism in all 100 videos, and none critically or thoughtfully engaged with the system. Brittney notes that “dieting is rooted in white supremacy and racism,” which is the only acknowledgement of this fact in all the data. Brittney fails to name anti-Blackness or settler colonialism specifically. Taylor, a white fat female-presenting person, says (referencing a horrible fatmisan encounter they had recently):

I’m acutely aware of the waters that we swim in. I know that fatphobia lives in all of us. The way that white supremacy makes room for everyone at the table, no matter what your race is, fatphobia makes room for everyone no matter size, weight, shape, race, whatever. So, I processed it with people that I love and trust and that are safe, got past it, great. (emphasis added)
I interpret Taylor’s remarks as an acknowledgement of the oppressive world we inhabit and how the oppressive ideologies that govern our world are internalized by and affect everyone. This is certainly true. However, Taylor’s acknowledgment ends here, implying that individualized harm responses are sufficient. White supremacy is used as a comparison to fatphobia and articulated as a separate entity. Moreover, it is framed as something unactionable and out of our control. Taylor presents these systems as discreet, thereby working to erase fat people of colour’s needs and disproportionate vulnerability to anti-fatness and healthism while using seemingly liberatory language about the pervasiveness of white supremacy. In the same vein, Jennifer, a white fat female-presenting person, says:

I am tired of watching women have to explain, justify, and apologize for their existence because they live in fat bodies. I hate it. And I still have the disgusting privilege of being melanin deficient. I’m not here to speak on that experience because it is not mine. I just want to include that I see you. And I love you. Please, please, let yourself be seen; let yourself be heard. (emphasis added)

They then share their experience of anti-fat violence as a white woman and urge people to stop equating people’s worth and health to the scale. Jennifer fails to name whiteness, white supremacy, or racism and instead opts for the strange, depoliticized language of “melanin deficient” that does not really address their privilege and certainly does not take responsibility for doing anything about, or with, that privilege. They claim it would be wrong to speak about white supremacy because they do not have any lived experience. What they fail to communicate is that as a beneficiary of white supremacy, they should be intimately familiar with it or at least actively learning. After metaphorically washing
white women’s hands of challenging white supremacy, they say, “I see you” and “I love you.” However, the language’s lack of specificity and critical thought renders the communities they are attempting to acknowledge invisible. No one is being seen or loved here because their identities and experiences are not being named. Finally, they place the onus on racialized people (the unnamed “you”) to fight to be seen and heard. All three of these videos attempt to challenge anti-fatness, diet culture, healthism, and definitions of health (all of which are rooted in white supremacy) but are not meaningfully addressing white supremacy or holding white people accountable for (re)producing it.

An additional way that the HAES discourse furthers co-healthism’s power to preclude systems-level analyses that would benefit racialized people’s wellness is the re-rooting of anti-fatness in patriarchy alone through white feminism. In their separate videos, Jordan and Brittney, white fat female-presenting persons, use Naomi Wolf’s words from her book, *The Beauty Myth: How Images of Beauty are Used Against Women*. They say: “a culture fixated on female thinness is not an obsession about female beauty, but an obsession about female obedience. Dieting is the most potent political sedative in women’s history. A quietly mad population is a tractable one.” Of equal interest, Fran, a white thin female-presenting person, uses a viral TikTok song to locate ‘diet culture,’ or anti-fatness and thin valorization, in men’s desire to exploit (white) women. Her TikTok features said song, captions of the lyrics, and a series of photos showing Fran move from being obsessed with dieting and exercising to embodying body acceptance and a HAES aligned performance of ‘health,’ ED ‘recovery’, and vitality. The lyrics to the song are:

I know Victoria’s secret!

Girl, you wouldn't believe!
She’s an old man who lives in Ohio,
Making money off of girls like me.
Cashing in on body issues
Selling skin and bones with big boobs.
I know Victoria’s secret!
She was made up by a dude! (emphasis added)

Through the popular song, Fran is situating the roots of anti-fatness and thin valorization in patriarchy, with its presumed goal articulated to be men’s domination over (white) women or girls like her. While whiteness is not named, the white TikTokers’ exclusive focus on patriarchal diet culture works to centre white women and femmes and their needs and experiences. All this discourse relocates the origins of anti-fatness in patriarchy alone and frames its purpose as wearing down (white) women’s and femme’s bodyminds, sanity, agency, and health. This relocation allows for co-healthist health promotion, or the achievement of an ideal ‘recovered’ bodymind, to be framed as fat liberation.

As touched on previously, Strings (2019) marks how anti-fatness is anti-Blackness. She links the development of anti-fatness to the rise of the transatlantic slave trade and Protestantism. These histories birthed the race-science-based rationale that Africans were biologically inferior because of their supposed inherent greediness and gluttony, along with the Christian ideology that overeating was sinful and savage (Strings, 2019). Since women are more often reduced to their bodies, these developments disproportionately targeted Black women (Strings, 2019). To make these power dynamics coherent in order to further Black subordination and white supremacy, white women needed to prove that they were not gluttonous and were instead carefully controlled,
civilized, and thus, godly and biologically superior (Strings, 2019). Thus, Strings (2019) puts forward that “the discourse of fatness as ‘course,’ ‘immoral,’ and ‘black’ worked to denigrate black women, and it concomitantly became the impetus for the promulgation of slender figures as the proper form of embodiment for elite white Christian women” (pp. 6-7, emphasis added).

This book came out two and a half to three years before these TikToks were posted. Long before this, scholars were making clear how fatness and excess are linked to Blackness and how anti-fatness disproportionately targets and harms racialized low-income women (Campos et al., 2006; Farrell, 2011; Gilman, 1985; Hobson, 2003; Strings, 2015). Robinson (2020) also makes clear how linking fatness to Indigeneity, particularly to Indigenous women, is used to justify and maintain settler colonial domination. A search of the tag #FearingTheBlackBody on TikTok shows it has over 218,000 views. This information is available to white women and femmes doing online fat activism, but white supremacy shapes popular discourse to mask and justify its violence. There is no doubt that patriarchy plays a role in anti-fatness and diet culture. However, HAES discourse prioritizes white women’s and femmes’ needs, health, and definitions of liberation. It also obscures how sexist anti-fatness is co-constituted with anti-Blackness and settler colonialism, and that anti-fatness is anti-Blackness and settler colonial domination and thus commits discursive violence.

The analysis presented in this section demonstrates how HAES practitioners commit discursive violence made possible by white supremacy and white feminism that masquerades as benevolence for the betterment of society. Co-healthism is at play here because all the discourse is evoking health, health promotion, wellness, ‘recovery’, and
social change, and all are shaped by white supremacy to preclude systems-level analysis that would benefit racialized people’s wellness and healing, challenge the status quo, and abolish systems that debilitate and disable racialized people. These creators share awful stories of fatmisanic encounters in attempt to create change, but their definitions of injustice, health, healing, and social change are born from white supremacist co-healthism. Co-healthist discourse like this actively harms racialized people’s wellness. Moreover, it allows fat liberation’s goal of abolishing anti-fatness and interlocking systems of oppression to be mutated in service of these oppressive systems.

One Right Way: Co-healthist Colonialism in HAES Discourse

My final point of analysis points to colonial logic as the underlying paradigm in HAES that promulgates Western biomedicine as the way to achieve health and liberation from anti-fatness. This colonial discursive process engineers Western biomedicine as the one and only way to better the body and, by extension, the body politic, solidifying colonial ways of knowing and demarcating health as normal (ideal) embodiment and fat justice as health promotion. This finding from the data supports Aphramor’s (2020) assertion that HAES’ focus on evidence-based practice and all-knowing attitude glorifies Western ways of knowing, Eurocentric supremacy, and colonial binary thinking about ‘right’ and ‘wrong.’ Twenty-two of the videos discursively cement HAES, and thus health, health promotion, fat activism, and social change, in Western biomedicine. They do this by marking the prevalence, harms, and flaws of anti-fat bias in health sciences scholarship that I have outlined in chapter one and presenting ‘better’ health sciences scholarship that asserts that HAES is the right way to be ‘healthy.’ Again, for those of us
that utilize allopathic\(^1\) medicine (whether willingly or not), marking the violence it perpetuates and presenting options for change is critical in creating full access to healthcare, healing, and well-being. People need care, and this often includes healthcare and medical intervention (although this intervention should be consented to and desired rather than mandated). Fat people deserve access to the same quality of healthcare as thin people. However, the reduction of health to biomedicine through the colonial insistence that (HAES) Western biomedicine should be the unilateral approach to defining health, responding to ill health, and combatting anti-fatness is an example of co-healthism’s power to demand perfectible (biologically and morally ideal) bodies, perpetuate colonialism, and mutate fat liberation’s purpose into health promotion.

The HAES TikTokers frequently reduce health and systemic anti-fatness to a biomedical phenomenon, thus correspondingly limiting HAES and fat liberation, by extension, in a biomedical paradigm. This is despite ASDAH saying that health enhancement should primarily be concerned with eliminating oppression and addressing the social determinants of health and health as a community project. Keep in mind that despite this previous assertion, they also describe HAES as an alternative ‘treatment’ for professionals and individuals to use, which is overtly biomedical language that, when paired with social justice discourse, as HAES most often is, as well as the notion that HAES is the best way to challenge anti-fatness and be healthy, allows for fat liberation’s goals to be morphed into enhancing the health of society with eugenic projects.

\(^{1}\) Allopathic is defined as “relating to traditional western medicine” (Cambridge Dictionary, n.d.).
Olivia, a white fat female-presenting person who works professionally with health sciences in some capacity, furthers discourse that health is biomedical. They say, in a mocking voice:

‘Oh look, another random person on TikTok making outrageous claims with no sources to make them feel better about their choices’ – NO, Andrew! I read. You know all of those peer-reviewed studies that you never actually read in your sophomore year of college? I read those. For my job! And there is a growing body of research on weight and body size that is emerging in the last five years that’s finding a lot of it is genetically predetermined. That all it takes is for one little chromosome to get a mutation, and OOPS—that person puts on weight very easily or can’t put weight on at all. And sure, some of those factors are external, but not nearly as much as the diet industry will lead you to believe. (emphasis added)

Olivia understands fatness as fundamentally genetic, with only some external contributing factors. Framing fatness as a simple matter of genetics is used here in an attempt to liberate fat people from anti-fatness. I interpret that by discursively distancing weight from ‘external’ factors, this creator attempts to dispute a causal relationship between diet, exercise, and fatness. However, by asserting this, they are obscuring how fatness can be externally influenced by political factors such as state violence; for example, settler colonial violence results in weight gain. This violence impacts people’s biological functioning and epigenetics but cannot be solely considered a biomedical phenomenon. This violence can look like many things, such as how intentional weight loss is unendingly encouraged by the state in Indigenous communities (Robinson, 2020).
This is important because, as presented in chapter one, we know that pursuing weight loss promotes weight gain (see Bacon & Aphramor, 2011, for example). Importantly, Western biomedicine’s impact on Indigenous communities is not restricted to contemporary efforts promoting weight loss. The violence of biomedicine reaches much farther back. For example, consider the residential school nutritional experiments where Indigenous children were systematically starved, altering their epigenetics and their children’s (Daniel, 2021). Moreover, between 60 and 70% of Indigenous people in Canada’s North experience food insecurity (Food Secure Canada, 2016), which has been linked to increased risk and incidence of becoming fat (Au et al., 2019; Pan et al., 2012; Rasmusson et al., 2019). Olivia adds an additional layer of Western supremacy by expressing the superiority of their knowledge due to their reading of peer-reviewed studies. They are not simply citing studies but demoralizing those who do not spend time reviewing scientific literature. This is likely not intentional but shows co-healthism’s power to engender colonial domination and understandings of health and embodiment.

Besides limiting HAES, health, and fat activism to a biomedical paradigm, HAES activists also insist that HAES is the best way to be healthy and combat anti-fatness. Maddison, a white thin female-presenting person, asserts the healthiest thing someone can do using their authority as a HAES professional:

Choosing to never diet again is the healthiest thing that you could do for yourself! […] As [a HAES professional], what I’m saying is that fruits and vegetables are good for you, but it doesn’t mean you have to obsess over them or that there can’t be room for fun foods in your diet. Exercise has tons of benefits, and you can totally have fitness goals, but obsessing about how much and how intense your
exercises are or feeling guilt or shame for not doing it is not healthy. Same goes with food. (emphasis added)

Maddison has the answer to good health and internalized anti-fatness. It is to stop dieting, eat healthy through IE, and exercise through IM. All one needs to do is give themselves the freedom to have some “fun foods” in their diet and not obsess about how intense their exercises are. Lorraine, a Black thin female presenting HAES professional, takes this colonial ‘One Right Way’ (Aphramor, 2020, para. 15) imperative a step further by saying that “people who care about their health don’t put their health at risk by engaging in dieting activities.” Never mind the evident moralization of caring about your health and performing ‘proper’ behaviours, what about the ubiquitous coercion fat people experience to diet, the cultural thin valorization that teaches women and girls that the only thing that matters about them is their body and beauty, or the real safety that dieting and weight loss may (temporarily and conditionally) provide to those constantly endangered by the state and anti-fat individuals (such as fat Black and Indigenous people or super/infinifat people for example)? They continue exalting Western medicine in HAES by claiming “people who actually care about their health would stay up to date on [HAES] research.” They are forceful that HAES is the way to perform health. Again, as I have stated, I do not believe this is an intentional devaluing and erasing of non-Western paradigms of understanding wellness or structural and political approaches to improving access to well-being. However, co-healthism makes this hierarchical discourse possible, frequent, and powerful.

Hunt and Holmes (2015) remind us that colonialism is fundamentally a “project intent on the erasure of Indigenous peoples” (p. 159). Besides the physical genocide, part
of this is done through the creation of strict colonial and cisheterosexist categories of who
counts as Indigenous that were meant to slowly write them out of existence (Hunt &
Holmes, 2015). They further a crucial insight from decolonial studies by saying that
“Indigenous knowledge and ways of being continually resist and disrupt” (p. 159)
dichotomous and binary thinking by “embracing a ‘both/and’ conceptual and political
stance for understanding contexts, spaces, identities, and multiple forms of interlocking
oppressions and violence as a way of resisting the ‘either/or’ dichotomous thinking of
colonial Euro-Western paradigms” (p. 159). This HAES discourse does not make room
for ‘both/and’; instead, it actively oppresses any challenge to its authority. The cementing
of health and HAES in Western biomedicine and the assertion of the framework as The
One Way to achieve well-being and freedom from anti-fatness reifies Western supremacy
and understandings of wellness and reinforces racial colonial hierarchical binaries that
maintain and strengthen co-healthism’s power. It thus reinforces co-healthism’s ability to
require ‘health’ (ideal embodiment) as an individual imperative and prerequisite to valued
subjecthood. Moreover, when HAES or Western biomedicine more broadly is
disseminated as the right way to promote health, the delineation of health promotion as
the scientific perfection of some bodies and elimination of others is reaffirmed. Because
of HAES’ situatedness in fat activism and social justice, the moralizing and positivizing
of this framework also supports the assertion that this form of health promotion is
necessary for the moral and biological betterment of society, thus allowing for fat
liberation’s purpose to be mutated into health enhancement. It does not escape me that the
TikTokers in this section are all professionals in the market or economy of HAES. These
professionals have something to lose from the decolonization of wellness and something
to gain from HAES’ continued co-healthist cooptation and mutation of fat liberation into health enhancement.

**Conclusion: Implications of the Co-healthist Mutation of Fat Liberation’s Purpose**

In this chapter, I have demonstrated how the current definition of healthism is too narrowly focused and fails to acknowledge the roles of anti-Black racism, white supremacy, colonialism, and ableism in healthism ideology, discourse, and practices. To address this gap, I proposed a new feminist-of-colour disability studies-oriented definition of healthism, which I coined as co-healthism. In addition, I have also argued that HAES supporters on TikTok have coopted fat liberation’s world-building goal through and with co-healthist discourse, effectively mutating it into health promotion. This co-healthist mutation is made possible within HAES discourse because of how the framework blurs health enhancement and social justice. Propagating co-healthism, HAES discourse only benefits those whose embodiment can be understood as ‘normal’ or biologically and morally ideal. At the same time, since HAES discourse buttresses co-healthism’s power to propagate neoliberal, anti-Black, ableist, white supremacist, and colonial domination and frame them as benevolent and necessary for the good of society, it also actively marks bodies coded as deviant and thus unhealthy (BIPOC, large fats, disabled people, Mad people, and chronically ill people) for violence and eradication.

The discourse allowable under a HAES framework enables a radical activist praxis like fat liberation to be easily coopted and mutated by people whose positionalities give them a vested interest in pursuing the power that comes with being categorized as ‘healthy’ due to its roots in whiteness and able bodymindedness. HAES is palatable, neoliberal, profitable, and thus very attractive to those with close proximity to normative
embodiment. The propagation of co-healthism within HAES discourse not only waters down the radical potential of fat liberation for transformative social change but also actively works against it by subverting its momentum to benefit the hegemonically powerful and maintain the status quo. By presenting HAES as liberatory, progressive, and benevolent through the multifaceted co-healthist cooptation of fat liberation discourse, its supporters can mask their discursive violence and obscure that HAES is leaving oppressive systems and structural violence completely intact. This violence is effective because it hides behind the scholars who laud HAES’ unprecedented efficacy and the supporters who link its origins to fat liberation, eliminating oppression, and improving society's well-being.

Of course, only some people who practice HAES participate in this discourse, and most people likely do it unconsciously. Nevertheless, even if one were to assume that the HAES discourse I have examined is not intentionally violent and is rather an honest attempt at fat liberationist work, I must make clear that it will still ultimately always be ineffective. To quote Lorde's (1984) seminal work, “the master’s tools will never dismantle the master's house. They may allow us temporarily to beat him at his own game, but they will never enable us to bring about genuine change” (p. 2). Politics that leave room for co-healthism’s eugenic regime will only ever benefit those who support and can embody the systems that prescribe the pursuit of worldwide bodily normalcy. Basing liberatory efforts on including a lucky extra few within the power that comes with being seen as healthy works at the expense of those whom most need fat liberation.

A feminist-of-colour disability studies lens offers fat activism an alternative way forward. Through its centring of disability justice, it reminds us that oppressive systems...
and norms must be abolished to build a more just and equitable world. Since the forces of oppression operate in tandem, they must all be challenged simultaneously for liberatory movements to avoid (re)creating the violence they seek to end. This work must be coalitional and centre the voices and leadership of multiply oppressed people. We need to organize around proximity to power (Cohen, 1997) and our shared desires and dreams for a liveable world where no one is left behind (Piepzna-Samarasinha, 2018; Sins Invalid, 2016). Thinking of power in this way has great liberatory potential for social justice struggles because it can potentiate oppressive systems being torn up at their roots and push for the complete transformation of systems that perpetuate domination. Armed with this ideology, we can fight back against HAES’ co-healthist mutation of fat liberation’s world-building goal and materialize a world where eugenic projects are no longer possible.
Chapter Three: Dreaming a Disability Justice Fat Liberationist Future for HAES

Through Collective Intuitive Eating/Movement (IE/M)

Overwhelmingly, the discourse surrounding IE and IM dominated the 100 TikToks. Figure four in chapter two shows that 28.0% of the analyzed hashtags evoked challenging diet culture and ED ‘recovery.’ Moreover, 27 of the 100 TikToks were focused on IE or IM. The data frequently represent health, HAES, and fat liberation as these individual behaviours. I discussed some of the limitations and harms of this pattern in chapter two. In this chapter, I want to complicate this critique with an analysis of the potentialities of this aspect of HAES. While ASDAH has ample reason to remove these practices from HAES’ core principles, they have evidently provided healing, wellness, joy, and community for those who embrace them. There are obvious benefits to the promotion of IE and IM. As discussed in chapter one, these include protection from the physical and psychological harms of dieting and intentional weight loss, as well as improved biomarkers of health. My data analysis also points to how those harmed by dieting, self-identified disordered eating, and (internalized) anti-fatness have found healing through these practices. Very broadly, HAES has propagated what I have interpreted from the discourse in the 100 TikToks as fat crip healing, food and exercise ‘freedom,’ and redress from (internalized) anti-fatness and disordered eating and movement. It has also given people a space to share their stories of pain, loss, grief, joy, reclamation, and healing with those who at least partially understand their experiences. HAES is thus, for some, articulated as empowering and in line with some aspects of fat liberation, such as the notion that fat people are whole and worthy, rejecting intentional weight loss, and the refusal of fat subjugation. These are evident potentialities of HAES
discourse, practices, and community. Therefore, in this chapter, I argue that HAES provides cathartic community care for those distressed by (internalized) anti-fatness, particularly people who identify with disordered eating and movement. However, as discussed in chapter two, given that co-healthist domination within the framework has made it exclusionary and harmful to anyone who cannot assimilate into ‘normal’ (ideal) embodiment (BIPOC, super/infinifat, disabled, chronically ill, and Mad people), this potentiality inevitably cannot result in meaningful social transformation or fat liberation under HAES’ current iteration. Fat liberation is fundamentally a collective movement committed to cross-movement solidarity. IE and IM fall short here due to their focus on individual behaviour and exclusion of people without the time, ability, and resources to practice them. As such, in this chapter, I also propose a fattened andcripped version of IE and IM rooted in collective care, mutual aid, healing as world-building, and radical solidarity that I call collective intuitive eating/movement (IE/M). The praxis of collective IE/M falls under a new iteration of HAES that focuses on people’s needs and desires for care rather than their health. I propose a name for this new iteration of HAES (Care at Every Size) and explain its utility in the conclusion chapter. In this chapter, I focus specifically on collective IE/M because of how central IE and IM are to popular online articulations of HAES and because of these principles’ evident harms, limitations, and potentialities. In the remainder of this chapter, I will further my argument by examining some potentialities of HAES discourse. I will then explain how IE and IM discourse and practices can shift productively by centering a feminist-of-colour disability studies lens. I will conclude by offering a work-in-progress prototype for collective IE/M that can further fat liberation and disability justice world-making.
I will explain in detail within a later section why I am avoiding the language of ‘recovery,’ but I need to make clear what I mean by ‘healing’ immediately. I have coined the idea of collective IE/M through my understanding of what it means to heal through a disability justice perspective that does not see disabled, Mad, fat, or crip folks as tragic, lacking, or pathological. This is radically different from mainstream conceptions, including those on TikTok, that frame healing as curative or as the erasure of fatness, disability, Madness, chronic illness, and bodymind difference broadly. As I have said in previous chapters, people need care, and this care sometimes includes consensual medical intervention. But in our current world, curative medical intervention is mandated under compulsory able-bodiedness/able-mindedness because it provides and furthers a social script that everyone should desire bodymind normalcy and a future without disability and Madness:

I use “curative” rather than “cure” to make clear that I am concerned here with compulsory able-bodiedness/able-mindedness, not with individual sick and disabled people’s relationships to particular medical interventions; a desire for a cure is not necessarily an anti-crip or anti-disability rights and justice position. I am speaking here about a curative imaginary, an understanding of disability that not only expects and assumes intervention but also cannot imagine or comprehend anything other than intervention. (Kafer, 2013, p. 27)

Kafer (2013) explains that under a curative imaginary, futures are imagined as wholly without disability; disability is seen as a preclusion to progress, while the erasure of disability is seen as progress. The original or non-collective version of IE and IM, along with the psychiatrized notion of ED ‘recovery’ are part of a curative imaginary that
sees internalized anti-fatness, disordered eating, and disordered movement as diseases rooted in individual pathology that can and must be fixed on an individual basis via psychological intervention (alone). Collective IE/M, shaped by a crip notion of healing characterized by collective care and reparative world-building, is anti-curative imaginary. It imagines fat, disabled, and Mad people in the future, not merely present but *desirable* and *essential* to materializing a liveable world. Importantly, it also *does* this world-building while capacitating us to continue this work.

**Cathartic Community Care: Potentialities of HAES, Intuitive Eating (IE), and Intuitive Movement (IM)**

The phenomenon of cathartic community care amongst the TikTokers who practice IE and IM has the potential to offer a framework of healing and care to ED communities and generate greater capacities to enact social change, practice collective care, and cultivate wellness as a resource and community project. By ‘cathartic,’ I mean releasing strong or repressed emotions leading to relief and, often, positive change and renewal (Strickland, 2001; Kuhns & Nathan, 2014). By community care, I mean a space that provides a sense of belonging, shared experience, and group bearing of shared trauma that facilitates interdependence; a sense of collective responsibility for each other’s well-being; and autonomous non-psychiatrized or medicalized care. Distinct from collective care and communities of care, which I will address later on, cathartic community care here is characterized by shared experiences of pain, grief, shame, and anger affected in communities by (internalized) anti-fatness. In other words, anti-fatness has distressed and disempowered many of the content creators in my data by devaluing their bodyminds and making thinness a prerequisite to (self) worth, often disrupting their
ability to comfortably and freely nourish themselves and move through the world. Anti-fatness has impeded their joy, self-worth, wellness, and bodily autonomy. Through a feminist-of-colour disability studies lens, I interpret their experiences as ableism. Their bodyminds have been assigned a value based on their embodiment and associated perceived moral behaviour. Under ableism, weight loss, thinness, and food restriction and preoccupation are their access to the relative safety that comes with bodymind normalcy, excellence, intelligence, and productivity. Of course, HAES supporters are various sizes and diversely positioned in other aspects of their identities, giving them varying degrees of power, privilege, and penalty under ableism. Their experiences are not the same. Nevertheless, they all share a need to combat internalized anti-fatness to experience peace, healing, and wellness. They share experiences of disempowerment and desire for a more just and fat-accepting world. My analysis of the data gathered suggests that access to a caring community can allow HAES practitioners, particularly those who perform IE and IM, to recognize and address what they understand as disordered eating/movement and food and body distress, to collectively discard debilitating feelings associated with these experiences, as they reflect on their significance, and to harness this collective practice towards challenging anti-fatness, which then also deepens feelings of understanding, renewal, and empowerment.

The HAES digital landscape evokes a generative affective response in its users, including Ellie, as she publicly shares her experiences with a receptive and compassionate group. Ellie, a white fat female-presenting person, describes how HAES has capacitated her to feel her feelings and care for herself and others through experiences of (internalized) anti-fatness. Her TikTok starts with text on the screen that
says, “Stop talking about self love and anti-diet culture. WHO CARES?!?” Ellie then begins to speak:

She does. [A series of pictures slide through of the creator as a child, starting with pictures of her under the age of 10 and moving to her as a teenager]. She who was told she was ‘too big’ for gymnastics. She also already hated getting her picture taken. She who was told she’d ‘lose the baby fat eventually.’ She who constantly compared herself to her thin friends. She who tried and failed to be the type of daughter he [a picture of her and her father appears] wanted. She who cried in the bathroom at prom because she felt hideous and lonely. She who had an ED and thought she was still too fat and unlovable. I do this for her and others like her. [She blows a kiss and gives a sombre and pained but supportive and loving look to the camera]. (emphasis added)

Not only has the online HAES community provided a space for Ellie to affectively feel her emotions publicly and share them with a receptive and understanding group, but it has also allowed her to care for herself through cultivating self-love and love for others. When talking about her pain and experiences of disordered eating, Ellie uses the past tense, insinuating she has experienced at least some relief and re-learned to eat in a way that is not as distressing to her. Regardless, she is no longer alone and is empowered to care for herself and others in an anti-fat world.

Paige, a white fat female-presenting person, too, asserts that fat community and fat-inclusive anti-weight loss discourse and scholarship provided relief from her feelings of misery:
I realized it was okay to be fat when I saw other people okay with being fat. And not just being okay with it but actively trying not to change it and living their life to the fullest [...] And then I started following people that posted infographics disproving all of these things that I thought were fact, and I was just presented with all of this new information that I just hadn't had before because the world is fatphobic and doesn't want you to realize that you can be fat and be fine [...] I realized it was okay to be fat because so many people were. And I had tried so hard [to lose weight] but it made me miserable. And I realized I had a choice between staying miserable in a body that was not going to change back to being thin…that thin ideal was—poof—gone after reading from so many scholars. My personal experience, everyone else’s experiences. I realized I can live my life and be fat or stall it and keep being miserable. (emphasis added)

Paige needed fat community and fat-inclusive scholarship, which she has indexed as HAES, to give up on the pursuit of weight loss. They articulated their experiences of pursuing weight loss as misery while framing accepting their fatness as living. This discourse makes clear that (internalized) anti-fatness stole their bodily autonomy and dominated their life. They believe that having a community to share their experiences with, (un)learn with, and depend on was necessary for them to move through their pain towards an abundant future.

Liz, a fat non-white not otherwise specified female-presenting person, adds to the conversation by speaking about the fear she had because of being told that she must lose weight or she would get diabetes and die:
When I was growing up, me being happy was not important. Me losing weight and being skinny was what was important. I started getting fat when I was like seven years old, and from then on, it was just, how can we make her skinny? Because there’s no way she can live in this fat body. I barely had any friends. I didn’t really talk to people. I tried to just be as insignificant as possible because I didn’t deserve to take up any space in the body that I was living in because my body was not a good body in the eyes of my parents and people close to me. Every day I worried that I would have diabetes and that I would just die, and that my life would be over because I was fat. And I wasted so much time not living [her voice breaks as she starts to cry], and I’m so sad for that girl who didn’t get to have anything because she was told that she deserved nothing. I wish someone had told me that I was allowed to be happy. (emphasis added)

Liz experienced pain, fear, and isolation for most of her life because she did not have someone to tell her that she was allowed to be happy or even exist as a fat person. Like Paige, she frames her ‘before’ life as ‘not living.’ (Internalized) anti-fatness and the WCHP told her she must pursue weight loss or die/be dead. HAES discourse works to disprove that fatness inherently causes death and disease and offers an alternative fat-inclusive understanding of wellness (although I think it is important to add that diabetics are not dead, and their lives are not worthless). The video shows that her pain no longer keeps her from actively enjoying her life, as she smiles, poses enthusiastically, and exudes joy when the video starts. Her parents and those close to her made weight loss a condition for acceptance and worth. HAES discourse and community do not. Significantly, her final hashtag under the video is #happy.
Ellie, Paige, and Liz all used the HAES hashtag to receive and provide cathartic community care by sharing their experiences of pain, resistance, and healing. Chloe, a thin white female-presenting person, and Daphne, a fat white female-presenting person, move the conversation more explicitly towards IE and food freedom. Daphne is focused on providing care and encouraging people to feel joy, self-love, and food freedom. On the other hand, Chloe speaks of being comforted in the online HAES community. Chloe says, “I have a huge appetite. I used to have an eating disorder; then, I had a relapse into an eating disorder. So, seeing videos of someone eating an adequate amount of food…OH, it’s just so comforting” (emphasis added). Mainstream TikTok and culture, more broadly, are saturated with messages pushing people to restrict and carefully control their food intake, whether it’s calories specifically, macronutrients, or certain foods. You do not often see content with people eating freely without restriction, especially fat people. HAES content, specifically IE content, is an exception. HAES content, including the data for this study, largely focuses on food but does so in a way that encourages plenitude, freedom, joy, trust, and fat acceptance through sharing knowledge on IE. This content propagates autonomy, companionship, compassion, and mentorship for those working to heal their trauma and associated restriction. Daphne’s video is a perfect example of this to complement Chloe’s expression of the comfort that the HAES community offers them. In their video, Daphne is eating a slice of loaded pizza while the text-to-voice reads their words, “this is a reminder that NO food can ever hurt you as much as a bad relationship with food can […] you deserve to eat, to enjoy, and to live” (emphasis added). Daphne is encouraging healing from (internalized) anti-fatness and promoting health as a resource by reminding people that their relationship with food is more important than what they
eat. This pairing points to how HAES allows people to feel cared for while also capacitating people to care for others. HAES TikTok is an online space of relief from an anti-fat world, particularly for those with distressing food, exercise, and weight preoccupation.

Dianne, a white thin female-presenting person, reveals that IE and IM allowed them to go from “weight obsessed, punishing myself with extreme diets and workouts” to radiating joy, confidence and freedom. The ‘after’ HAES pictures included in their video show them having gained some weight, but in the photos, they have written ‘worthy’ and ‘lovely’ on their stomach fat. They share this journey to food and exercise autonomy to care for and mentor others going through the same pain. Taylor, a white fat female-presenting person, also uses HAES, specifically IE, to heal their inner child and relationship with food. She notes that in “recovery,” she likes “being my own parent during the lunch packing and meal making process.” She gets to “love” on herself, unlearn the moralization of food, and provide herself with gentle nutritional guidance in line with a HAES framework. She says, “I repair harm and build trust with little [Taylor] as I make decisions about what to eat based on her preference, nutrient balance, and planning for hunger, as I mentioned in a previous video. I’m wishing you small but mighty gestures of repair” (emphasis added). Re-learning how to eat through IE has, in her words, allowed her to repair harm and learn to trust and love herself. IE has provided her with catharsis. But she doesn’t stop there. She has taken the time to share these insights with the HAES community and provide support for them as well. The same goes for Rhiannon, a white fat female-presenting person who uses the HAES hashtag to
promote IM and push back against the common ideology that no one ever regrets a workout, thereby caring for themselves and others. They say:

I regret every workout I ever did where I forced myself to do it, even though my mind or my body or both were telling me that what I actually needed was rest. I regret the times that I worked out to the point of pain, tears, injury, or to the point of feeling superior to other people. I regret the times when my workouts were motivated by self-hatred, insecurity, comparison, people-pleasing, or self-punishment. And by the way, all of these scenarios were normal for me, as they are for many people. So, if the way that you’re moving your body isn’t bringing you joy, you can either change the way you're moving your body, or you can just take a break from exercise for a while. Both of those are better options than living a miserable life. (emphasis added)

They use the same words as Paige, asserting that HAES, through IM, has given them a practice where they can experience relief from the “misery” that anti-fatness affected in them. HAES discourse and behaviour provided catharsis and healing for them and empowered Rhiannon to help others accomplish the same.

In a separate TikTok from the one already discussed, Paige supports the healing and capacitating potential of IE via a duet. They nod along to discourse that explains how IE has changed their life:

Croutons and dressing on your salad does not take away from the nutrition.

Adding less nutrient-dense food to more nutrient-dense food does not take away from the total nutrients from that meal […], and it’s not just your physical well-being, but also your mental well-being. To put it simply, eating food you enjoy
increases your quality of life. So don’t let anyone shame you for how you get your nutrition. (emphasis added)

IE allowed Paige to release the shame that anti-fatness affected in their relationship with food. The cathartic affect of eating intuitively and sharing this practice with others is evident in their agreement that IE has improved their physical and mental well-being.

Clearly, HAES is providing cathartic community care for those traumatized by (internalized) anti-fatness, particularly people who identify with disordered eating and movement. Not only does this capacitate individuals to feel their feelings and come together in shared pain and healing, but it also capacitates them to mark and challenge anti-fatness. This is a clear potentiality of HAES that is largely dependent on IE and IM. Again, ASDAH has stated their intentions to remove these from HAES’ core principles given that not everyone has access to them, nor the ability or desire to perform them. They do not view IE and IM as essential to a HAES framework given their focus on individuals, particularly already largely privileged individuals, and state they could be moved to ‘tools.’ While I completely understand and agree with this logic, as someone who needed IE and IM to help heal from my internalized anti-fatness and cope with its external forces, transform my relationship to wellness, as well as find redress from my food, exercise, and weight preoccupation and distress, I do wonder what this might mean for HAES’ ability to reach those in similar situations. Realistically though, IE and IM would likely still proliferate widely as existing HAES supporters are highly invested, and HAES professionals make their living on coaching these behaviours. Regardless, moving IE and IM to ‘tools’ does not address the underlying concerns that these practices are steeped in co-healthism, as discussed in chapter two, and not accessible or useful to the
majority of people harmed by anti-fatness. Thus, I propose collective IE/M as an evolution that does not abandon these tools’ potentialities but addresses these core concerns.

Cultivating Cathartic Collective Care Through Collective IE/M: Expanding HAES Discourse through a Feminist-of-Colour Disability Studies Lens

HAES supporters must radically politicize IE and IM and move towards collective care to dismantle the oppressive co-healthist rhetoric, projects, and behaviours that HAES discourse spreads. I see cathartic community care as a precursor to collective care, which sees wellness as a shared responsibility rather than an individual one (Mehreen & Gray-Donald, 2018). Originating in Black feminist and disability justice praxes, collective care emphasizes joint accountability, interdependence, and collective empowerment and intentionally cultivates non-hierarchical and collective organizing strategies (Mehreen & Gray-Donald, 2018). The community care in the data does not live up to collective care because the latter asks that activists address the interlocking modes of domination and root causes of deteriorating health within their communities while fighting against large-scale oppression (Mehreen & Gray-Donald, 2018). The data for this study are overwhelmingly dominated by white feminine and female-presenting people’s needs, steeped in co-healthism, and carrying out co-healthist mutations of fat activist ideology to serve eugenic projects. As such, these HAES supporters are most definitely not performing collective care. To address the root causes of deteriorating wellness, eating, movement, and weight distress, as well as anti-fatness more broadly, IE and IM must shift from individual behaviours to collective organizing rooted in mutual aid. Only then could IE and IM act as fat liberation and disability justice, address the social,
political and environmental determinants of health, and capacitate healing for those
disabled by and experiencing the most (internalized) anti-fatness.

*Eating, Movement, and Body Distress is a Complex Social Justice Issue: Challenging the ED ‘Recovery’ Narrative*

In chapter one, I explained the physical and psychological harms associated with
dieting and intentional weight loss, which include the development of what is understood
as disordered eating and movement. Diet culture and mainstream media prescribe
intentional weight loss and restriction to everyone, with thinness required to access
power, inclusion, and relative safety under white supremacy, ableism, colonialism, and
anti-fatness. Most doctors continue to prescribe weight loss to fat people and offer it as
the only course of care for any concern fat people bring to them. These physical and
psychological traumas should not be downplayed. However, there are particular concerns
with what people understand as disordered eating that I want to bring attention to because
they uniquely affect wellness. Harrison (2019) notes that severely restricted eating can
lead to:

- liver damage, osteoporosis, heart attacks, and death. Purging carries many of the
  same risks, and it can cause additional cardiac problems such as palpitations,
  arrhythmias, and heart failure, in addition to painful tearing of the esophagus and
  an increased risk of esophageal cancer. Laxative abuse can cause electrolyte
  imbalances and severe dehydration. And many people with disordered eating, as
  well as those with compulsive exercise behaviours, experience hormonal
  abnormalities, among them irregular or missing periods, low sex drive, infertility,
and thyroid problems. Disordered eating and compulsive exercise can also trigger IBS and other digestive issues and functional gut disorders. (pp. 147-148)

Additionally, a meta-analysis that examined several countries confirmed that the prevalence of suicidal behaviour in people diagnosed with anorexia nervosa and bulimia nervosa is higher than in the general population (Preti et al., 2011). Another study found an overall general increased mortality risk for those diagnosed with all types of EDs (Arcelus et al., 2011). These risks are all combined with the obvious mental distress accompanying (internalized) anti-fatness, fear of food, fear of gaining weight, and self-hatred. Importantly, disordered eating disproportionately occurs more frequently among individuals who experience food insecurity (Becker et al., 2017; Rasmusson et al., 2019).

In a study conducted with USA residents, Becker et al. (2017) found that those with the worst food insecurity also had significantly higher levels of disordered eating, worry, and weight preoccupation. Seventeen percent of those with the worst food insecurity reported ED behaviour, which is much higher than the general population. The majority of participants in this study were Latinx and Black. Chronic physical and mental health conditions also increase the risk of food insecurity and the risk increases with the number of conditions an individual is diagnosed with (Tarasuk et al., 2013). These are only a handful of examples of how eating, movement, and body distress (or disordered eating) is a complex multi-issue social justice concern shaped by interlocking systems of oppression.

As mentioned in chapter one, literature shows that IE is associated with reduced ED symptoms (Bacon & Aphramor, 2011; Provencher et al., 2009; Tylka, 2006). However, in resisting the urge to prove efficacy and frame IE as evidence-based practice,
more importantly, the data depicting HAES supporters’ lived experiences demonstrate
that IE and IM can provide redress and healing from emotional pain and food, exercise,
and weight preoccupation affected by (internalized) anti-fatness. While many content
creators supporting HAES and IE use the language of ‘recovery’ to describe this healing,
I want to problematize the ED ‘recovery’ narrative and explain why I have been avoiding
this language.

Critical feminist, anti-psychiatry, and mad studies perspectives on what is
understood as disordered eating identify the root ‘problem’ of EDs in society rather than
frame them as illnesses, diseases, or individual pathologies (LaMarre et al., 2015, 2019;
LaMarre & Rice, 2017; Rinaldi et al., 2016; N. Schott, 2015; N. D. Schott, 2022; N. D.
Schott et al., 2016). They also make clear that ED-associated behaviour, rigid rules, and
distress around food, exercise, and weight are, in fact, ordinary in our fatmisic world, and
so ‘recovery’ is counter-cultural and paradoxical (LaMarre & Rice, 2016; N. D. Schott,
2022). Speaking to the narrative of ‘recovery’ from psychiatric disabilities or Madness
more broadly, Howell and Voronka (2012) explain that ‘recovery,’ along with ‘resilience,’
have been coopted from anti-institutionalization movements and Mad identifying people
by medicine and the field of psychiatry. This cooptation of ‘recovery’ frames
psychological distress and difference as ‘illness,’ thereby locating the problem in
individuals rather than violent systems and institutions (Howell & Voronka, 2012). They
explain that this erases the structural violence that shapes people’s wellness, pathologizes
difference as a deficit, and removes power and decision-making authority from Mad-
identified and psychiatristized people regarding their lives and care. This now medicalized
and psychiatristized notion of ‘recovery’ prescribes medical and psychiatric care as the only

care, a *necessary* intervention for people to live “meaningful lives” (p. 4). Under psychiatry, the only way to live a meaningful life is to recover (be ‘cured’) or be brought back to a ‘normal’ bodymind. This language thus upholds a curative imaginary that pushes for ‘perfecting’ humankind by eradicating bodymind difference.

The problematics of ‘recovery’ also relate to its impossibility within the essentialist understandings of ED recovery prescribed by psychiatry. While ED ‘recovery’ criteria are intended to be lifesaving, they are paradoxical to mainstream neoliberal diet culture, within which ‘recovering’ people have to live (LaMarre & Rice, 2016; N. D. Schott, 2022). Moreover, psychiatrized and medicalized understandings of ‘recovery’ informed by biopedagogies can propagate complex performances of it “as a place of perfectly balancing the demands of neoliberal health logics and prescriptions for eating disorder recovery” (LaMarre & Rice, 2017, p. 12). ‘Objective’ conceptualizations of recovery are thus difficult to achieve and can be constraining and unobtainable (LaMarre & Rice, 2016). Importantly, there is work in the field that conceptualizes recovery in non-medicalized and psychiatrized ways that make room for fluidity, agency, relationality, and collective care (LaMarre & Rice, 2020; Rinaldi et al., 2016). Additionally, I am not saying that people who identify with disordered eating do not want or deserve care or should never seek medical or psychiatric care. Nor do I intend to downplay the pain that ED communities live with. However, given the implications of this language, I am choosing to avoid ED ‘recovery’ and instead utilize ‘care’ and ‘healing,’ which have been reclaimed and embraced by marginalized communities, particularly by BIPOC and disabled communities (Piepzna-Samarasinha, 2018).
Healing as Disability Justice and Fat Liberationist World-Building

Under a feminist-of-colour disability studies lens based in disability justice, the goal of healing is not to ‘recover’ or achieve bodymind normalcy. While not always free from or immune to a curative imaginary, the language of healing allows us to resist the medicalized and psychiatrized language of ‘recovery’ that individualizes and medicalizes structural problems, frames healing as linear, devalues and eradicates bodymind difference, and forces compliance in psychiatrized people. Piepzna-Samarasinha (2018) notes that “mainstream ideas of ‘healing’ deeply believe in ableist ideas that you’re either sick or well, fixed or broken, and that nobody would want to be in a disabled or sick or mad bodymind” (p. 103). On the other hand, a crip notion of healing thinks of it as “less pain, less anxiety, more flexibility” (Piepzna-Samarasinha, 2018, p. 103). She also speaks about crip healing as “increasing possibility, about learning, about trying to love all our survivor madness, and about shifting our communities to ones where crazy [is] really okay” (p. 234).

Under my theoretical lens, I also think of healing as being capacitated to feel more joy and love for oneself, one another, and the world; caring for yourself, others, and the planet; coming together in community as people who have been hurt by systemic violence; naming and processing trauma; abolishing systems of oppression; and building a livable world. Similarly, when I think of care, I think of collective care, and now, cathartic collective care (a merging of collective care and cathartic community care). I also think of mutual aid. This framing can move IE and IM from individual, privileged, and single-issue-focused practices to collective IE/M, a radical collective healing practice
and form of prefigurative politics. As I have said, I am not calling for an abandonment of wellness seeking, formal healthcare, self-care, individual health-promoting behaviours, or seeking relief from pain and distress. I am calling for a feminist-of-colour disability studies-oriented expansion of what these practices look like.

*Prototyping Collective IE/M*

Before I can outline what collective IE/M could look like, I must delineate what IE and IM (its precursors) are and where they are lacking. IE and IM both have a set of principles. IE’s principles are as follows: reject the diet mentality; honour your hunger; make peace with food; challenge the food police; discover the satisfaction factor; feel your fullness; cope with your emotions with kindness; respect your body; movement- feel the difference; honour your health-gentle nutrition (The Original Intuitive Eating Pros, n.d.). To summarize, these principles essentially prescribe that individuals give up on the pursuit of weight loss and restriction and give themselves unconditional permission to eat what we want and how much we want. Instead of framing foods as ‘good’/ ‘bad’ or ‘healthy’/ ‘unhealthy,’ IE says to choose our food and the amount we eat according to hunger, fullness, desire, and satisfaction while keeping in mind diversity, nutrient density, and how food makes us feel physically. It also asks that we feel and attend to our feelings in sustainable ways that address the root causes of these emotions. Finally, it also prescribes IM, or moving in a way and to the degree that feels right to each individual, while focusing on how movement makes us feel. Tally Rye, an anti-diet and HAES personal trainer, expanded these principles to give more guidance on how to move

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2 Piepzna-Samarasinha (2018) defines prefigurative politics as “a fancy term for the idea of imagining and building the world we want to see now. It’s waking up and acting as if the revolution has happened” (p. 149).
intuitively. IM tells people to reject the diet mentality; honour your appetite for movement; stop when satisfied; make peace with exercise; challenge the fitness police; discover the feel good factor; managing emotions; accepting your body; and gentle guidance (Rye, 2020). It essentially encourages focusing on how movement makes your body feel, exploring what you like and can do comfortably, giving yourself unconditional permission to rest or move as little as you want, and abandoning rules around what kinds of exercise you can do, how much you ‘should’ do, or what kinds are ‘best.’ It also asks that people acknowledge that exercise is only one way of managing our emotions and not a stand-in for other forms of care. It does not require setting personal goals (and, in fact, recommends against it when starting) but teaches us that if we want to, we can set ones centred on what our body can do or how we feel rather than what our body looks like.

These principles are all easier said than done. A lifetime of anti-fatness, co-healthism, and diet culture telling us to restrict, aim for perfection, and do high-intensity interval training or cross-fit five times a week cannot be undone by simply learning about these practices. Moreover, for those preoccupied with food and exercise, IE and IM can quickly become just another set of rules to follow ‘perfectly.’ That was my experience, at least. It takes years, and maybe lifetimes, to distinguish if you are doing something because it feels good intuitively or because it feels good because society has told you it is good and because we get societal praise for doing it. In reality, this distinction will never be entirely possible for any individual in the oppressive and violent world we live in. So, while these principles may benefit some, they are still prescriptive, make room for co-healthism, and centre a white and Western understanding of wellness. They are missing information about accessing culturally appropriate community-based healing resources
(Kinsey, 2022). They also do not address culturally appropriate eating practices (ex., prayer or gratitude) or spirituality and mindfulness’s more significant healing potential (Kinsey, 2022). They are also missing any acknowledgment of disability or chronic illness that recognizes the limitations of certain bodies, regardless of diet; even your favourite foods can have you suddenly projectile vomiting or defecating, and some of us may be dependent on others to buy and prepare our foods as well as feed us. Another glaring absence is that not everyone has secure access to food or the money to buy what we most want to eat or what would make us feel good and satisfied. There cannot be a universal list of principles because there is no universal experience of embodiment, wellness, (internalized) fatmisia and ableism, or food and exercise preoccupation and distress. We cannot follow white feminism’s trend of universalizing hegemonic experiences. Instead, our discourse needs to focus on how fatness, wellness, eating, movement, and healing are sociopolitical and sociocultural experiences.

So, in the following sections, I communicate what changes we must make to cultivate collective IE/M. First, who is centred and desired in the IE and IM community needs to shift to include the most marginalized: super/infinifat, BIPOC, immigrant, disabled, chronically ill, poor and working class, queer, and trans people. More specifically, it needs to centre the leadership of those multiply marginalized by the interlocking systems devaluing these identity categories. We also cannot leave our men and masculine people behind, as the feminization of fat and distress around food is rooted in white supremacist patriarchy and dismantling this system is essential. We need as many people as possible to come together to heal and care for one another in community while centring and valuing the knowledge and leadership of diversely positioned people.
This means that the principles must be collectively modified, open to evolution, and interpreted and practiced in whichever way collectives determine is best for them physically, culturally, spiritually, and emotionally. For example, Kinsey’s (2022) articulation of decolonized IE and IM emphasizes food, movement, and eating as mindfulness, spirituality, and positive affirmation. Another example is that for people experiencing food insecurity, the focus needs to shift to finding ways to feel shameless about eating enough food and less about what it is or its nutritional density (C. Harrison, 2019).

Second, food access and sovereignty, abolition, and decolonization must become central to the practice. I acknowledge that this discussion is largely beyond the scope of my research, but leaving it absent is simply inappropriate. Food freedom cannot happen under settler colonial occupation, carceral governance, or global racial capitalism. As Indigenous people resist being forcibly removed from their lands, impoverished, imprisoned, and killed, solidarity, decolonization, self-determination, and land-back must be understood as essential to collective healing. As mentioned in chapter two, 60% to 70% of Indigenous people in Canada's North experience food insecurity (Food Secure Canada, 2016) and in the Fall of 2020, ten percent of Canadians aged 12 and up experienced food insecurity (Polsky & Didier, 2022). Moreover, the global North steals over ten trillion Northern dollars a year from the global South, which is more than 30 times the amount of aid they receive annually (Hickel et al., 2022), leaving behind massive amounts of poverty and food insecurity. A Statistics Canada (2022) report shows that from 2020 to 2021, more than 30 percent of adults imprisoned yearly in Canada were Indigenous, despite them making up only five percent of the population. The same report
marks that of the non-Indigenous adults forced into prisons, one out of six of the adults these same years were visible minorities, with Black adults making up 10 percent of the total people put in prison while only representing four percent of our population. These statistics do not include the tens of thousands of people imprisoned in Canadian migrant detention centres yearly. Between 2006 and 2014, Canadian detention centres imprisoned 87,317 migrants without charge, some of whom were held for up to ten years (Never Home, 2015). Not only do imprisoned people lack autonomy over their food choices and portions, but the quality and amount of food have been found to be substandard by Canadian federal government auditors (Harris, 2019).

Additionally, in Canada, tens of thousands of intellectually disabled people are still institutionalized in large institutions, group homes, hospitals, and long-term care homes (Spagnuolo & Earle, 2017). Evidently, institutionalized people also do not have access to food freedom. Linton (2022) notes that for-profit private companies outsource food supply in hospitals, prisons, and nursing homes. Linton (2022) shows that these meals are too small, terrible-tasting, often expired or rancid, culturally and religiously inappropriate, and often deemed inedible by institutionalized people. Of course, decolonization and the abolition of prisons, long-term care homes, borders, global racial capitalism, institutionalization, and all of the interlocking systems of oppression are concerned with much more than food and movement freedom. But there can be no food and movement freedom without decolonization and abolition; they are central to collective IE/M, and so are worldwide wealth redistribution and policies that provide a universal basic income, social services, and affordable housing. Essentially, cultivating
food and movement freedom must centre eradicating state violence; it is not an individual endeavour.

The now marked necessity of radical and collective social change for cultivating food and movement freedom brings me to the third shift collective IE/M can materialize: the practice of interdependence and mutual aid. As inflation and natural disasters rise, and more and more people are left without basic survival needs, including food, mutual aid is more important than ever (Spade, 2020). To perform mutual aid, practitioners of collective IE/M need to organize via interdependence and collectivity. The disability justice principle of interdependence states:

We see the liberation of all living systems and the land as integral to the liberation of our own communities, as we all share one planet. We attempt to meet each other’s needs as we build toward liberation, without always reaching for state solutions which inevitably then extend its control further over our lives. (Sins Invalid, 2016, p. 18)

Spade (2020) defines mutual aid as survival work (sharing resources and support with neighbours and community members in need) done in “conjunction with social movements demanding transformative change” (p. 1). He notes that mutual aid is amongst the most effective forms of organizing for social justice because it directly capacitates people to survive, join movements, and mobilize; spreads knowledge about the root causes of injustice and inequity; cultivates participatory and non-hierarchical collectives; and also allies people from diverse social positions because it is based in having shared needs rather than a shared identity. It is prefigurative politics that builds new ways of living and forges radical cross-movement and cross-identity solidarity
This solidarity is a radical form of consciousness-raising because community members can honour differences while working across them (Spade, 2020). This works because people can learn from their diversely positioned comrades while sharing their own knowledge and lived experiences. Regarding collective IE/M mutual aid, people need access to food and movement freedom and a community free from diet culture, anti-fatness, and co-healthism. People also desire healing from the pain affected in them by these systems. To meet these needs, practitioners must form collectives in their communities to help each other create these realities. While people come together to form community-run food banks, install solar panels, grow community gardens and farmers markets, build hydroponics systems, pool finances for people in need, and share and eat food together, consciousness-raising on unlearning diet culture, joyful movement, the racial origins of anti-fatness, eating intuitively, collective access, dieting as a political sedative, police abolition, fat liberation, disability justice, and community healing could occur simultaneously. To further practice collective IE/M, we could also materialize community-based care for people in pain from (internalized) anti-fatness, such as affordable counselling clinics that operate on a sliding scale and care webs3 or aid pods4 that ensure someone has a comrade to stay with them when they are experiencing suicidal

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3 When I say care webs, I am using Piepzna-Samarasinha’s (2018) articulation of care that “break[s] from the model of paid attendant care as the only way to access disability support. Resisting the model of charity and gratitude, they are controlled by the needs and desires of the disabled people running them. Some of them rely on a mix of abled and disabled people to help; some of them are experiments in “crip-made access”—access made by and for disabled people only, turning on its head the model that disabled people can only passively receive care, not give it or determine what kind of care we want. Whether they are disabled only or involve disabled and non-disabled folks, they still work from a model of solidarity not charity—of showing up for each other in mutual aid and respect” (p. 41, emphasis in original).

4 Airborne (2021) defines an aid pod as “a small group of people who self-organize to provide support to each other in whatever ways they mutually agree to” (p. 5).
ideation or self-hatred, bring them meals when they are too depressed, anxious, pained, or sick to leave their bed, or feed them when they cannot feed themselves. People also need access to healing movement, which could look like many things. Moving can be a form of healing. It can cultivate mindfulness and grounding (Kinsey, 2022), reduce pain, improve flexibility, improve mood, prevent injuries, reduce stress, improve self-esteem and body image, and benefit physical and mental well-being in so many more ways when done intuitively and joyfully (Rye, 2020). But to engage in mindful movement (of any form) that brings joy and healing, people need access to their basic needs, which we can strive to provide one another with through mutual aid and political action. This is fundamentally what is most important. However, people also need access to affordable, safe, accessible, and appropriate methods of movement. This could look like people offering others access to their apartment complex’s pool; sliding scale physiotherapy; carpooling to affordable and accessible activities at community centres; teaching others grounding activities and meditations; fighting for more green space and less gentrification; sliding scale classes for BIPOC, low-income, disabled, queer, and trans people where instructors give modifications for people with varying mobility; demanding bike lanes, accessible transport, and walkable cities from your city counsellor; or holding your friend’s hand through deep breathing or grounding exercises while they have a panic attack.

IE and IM supporters acknowledge dieting is a political sedative (see chapter two). Thus, I am calling for political action as we fight the urge to diet, starve, restrict, or purge and work collectively to heal our relationships with food, our bodyminds, and the world we inhabit. We need mutual aid, cathartic collective care, and allied social justice
movements to actualize any large-scale food and movement freedom. Starvation, food and exercise preoccupation, and the pursuit of thinness are survival tactics in a violent co-healthist world that stops at no end to eradicate fat people and anyone outside of ‘normal’ (morally and biologically ideal) embodiment. Thinness provides tangible power and protection to those who were never meant to survive in our current world. It is not as simple as telling people to love themselves, eat, and move joyfully. Collective IE/M can bring those whose bodyminds have been assigned less value under the interlocking systems of oppression together in healing and start to actualize the just and liveable world we desire now in the present moment.

I want to be clear—I am not providing a set of rules or a definite blueprint for what collective IE/M should or will look like. Mutual aid organizing and disability justice are collective and inherently anti-hierarchical. I do not have all the answers nor anticipate that this organizing will be easy, perfect, or free from ethical scrutiny. Groups will have to learn and share knowledge on how to do mutual aid, form care webs and aid pods, and find ways of working together, addressing harm, and solving conflicts that work for them. No individual or collective will be able to provide all this aid and accomplish these goals. Considering this, I propose my notion of collective IE/M as a prototype. Hamraie (2020) distinguishes between blueprints for livability and prototypes for more livable worlds. Neoliberal and eugenic notions of livability prescribe “design blueprints, or outcomes of completed design decisions, for desired futures” (Hamraie, 2020, p. 408). Feminist and critical disability studies scholars counter this prescriptive and concrete method of looking at livability with the idea of prototyping, which is “incomplete, iterative, and fractioned” (Hamraie, 2020, p. 408). While Hamraie is focused on urban design,
sustainability, and livable cities, given that disability justice, fat liberation, and mutual aid are world-building projects, I believe this concept is fitting. Collective IE/M will unfold as it is practiced by collectives of marginalized people who know best what a liveable world looks like.

Because of this thesis’ focus on cooptation, I must touch on the potential cooptation of collective IE/M. Were it to be popularized, content creators could no doubt find a way to coopt it for profit. But the focus on collectivity means that it is inherently against focusing on individuals and for collective action that benefits the most marginalized. It is rooted in abolition, decolonization, food and movement sovereignty, collective decision making, fat liberation, disability justice, and mutual aid, meaning it is not easily divorced from collectivity. Original IE and IM discourse leaves room for co-healthism and, thus, individualization. Collective IE/M does not. It is focused on cathartic collective care, not health. At the very least, the ideology of collective IE/M braces us to organize against cooptation and stand in solidarity against the systems that benefit from watered-down versions of our movements. Activism that blends fat liberation, abolition, decolonization, and disability justice is already happening. The social media of activists like Imani Barbarin, Caleb Luna, and Marquisele Mercedes demonstrate that work that stays true to the radical principles of the former movements can exist and flourish online. Adding collective IE/M to this work allows it to reach those distressed by internalized anti-fatness, food, weight, and exercise preoccupation and offer immediate care and healing while we organize for a liveable world.
Conclusion

HAES supporters love and cherish IE and IM as self-care and healing. I demonstrated this by highlighting the large proportion of posts on TikTok focusing on these practices and unpacking some of the specific discourse. Through this analysis, I argued that HAES is providing cathartic community care for those distressed by (internalized) anti-fatness, particularly for people who identify with disordered eating and movement. The discourse in the data communicates a desire for, and some materialization of, community care. However, this care leaves out multiply marginalized people, is only accessible to largely privileged people, and does not extend into combatting large-scale social injustice more broadly. As seen in chapter two, it also actively propagates co-healthism’s ability to harm and eradicate bodies marked as deviant and thus unhealthy. Rather than accepting that IE and IM will always be co-healthist, leaving those who need its care behind, giving up on the healing and community potential that IE and IM hold, or cementing them as only accessible and useful to a privileged few, I proposed a fattened and cricked version of IE and IM based in cathartic collective care, mutual aid, and radical solidarity that is anti-curative imaginary; collective IE/M. I did this using a feminist-of-colour disability studies conceptualization of ableism, a disability justice understanding of healing, and a focus on care instead of health. My iteration of collective IE/M is not a prescription on how to move and eat that will look the same for every individual or collective, but rather, it is a prototype for a radical shift in how IE and IM practitioners view health, wellness, care, ‘recovery,’ healing, and health promotion. Collective IE/M is prefigurative politics in which “we move together, with no body left behind” (Sins Invalid, 2016, p. 7).
Conclusion: Towards (Health) (Community) (Collective) Care at Every Size (CAES)

“I am dreaming the biggest disabled dream of my life—dreaming not just of a revolutionary movement in which we are not abandoned but of a movement in which we lead the way. With all of our crazy, adaptive-deviced, loving kinship and commitment to each other, we will leave no one behind as we roll, limp, stim, sign, and move in a million ways towards cocreating the decolonial living future.” (Piepzna-Samarasinha, 2018, p. 135)

The aim of this thesis was to interrogate the liberatory potential of the HAES framework. It was born out of an identified need to mark co-healthist domination within HAES discourse; my lived experience and desire to hold myself and other users and proponents, especially those who live with privilege from white, non-Indigenous, thin, non-disabled, and middle or upper class subjectivities, accountable to our complicity in maintaining the interlocking systems of oppression while seeking freedom for ourselves; and a dream of a framework of care, healing, and liberation that leaves no body behind. It was intended to pay careful attention to the histories of eugenics in health promotion and violence of a curative imaginary (Kafer, 2013) that does not see disability in the future, while also making fat and crip space to think about peoples’ needs for care, healing, well-being, and wellness-capacitating environments. My analyses have allowed me to conclude that HAES needs to shift from a focus on ‘health’ to a focus on care. Ultimately, I hope for my research to be used collaboratively by ED communities of care, advocates of health equity, and disability justice and fat liberation activists seeking to further this work.
To begin this work, I decided on a feminist-of-colour disability studies lens that deploys disability as a method for making clear how interlocking systems of oppression operate simultaneously and co-constitute one another to assign varying value to certain embodiments (Schalk & Kim, 2020). Drawing on queer, crip, and woman-of-colour feminisms and buttressed by the logic of disability justice, this framework allows for organizing around proximity to power rather than shared identity categories (Schalk & Kim, 2020). Pulling from my chosen theoretical orientation, I curated three key research questions: 1) What positionalities advocate for HAES on TikTok, and how are they speaking about it/framing it? 2) What are the potentialities, limitations, and harms of how the HAES framework is popularly articulated on TikTok? 3) How can HAES discourse shift productively by centring a feminist-of-colour disability studies lens? I then performed a TikTok CDA to examine how HAES is understood and disseminated by contemporary activists via TikTok, unpack the power relations embedded in this discourse, make meaning surrounding what the TikToks are doing discursively, and dream of a framework of care that centres the needs and desires of BIPOC, super/infinifat, disabled, chronically ill, and Mad people.

Through my TikTok CDA I formulated three main arguments: 1) the current definition of healthism is too narrow and fails to acknowledge the centrality of anti-Black racism, white supremacy, colonialism, and ableism in healthist ideology, discourse, and practices; 2) HAES supporters on TikTok have coopted fat liberation’s world-building goal through and with co-healthism to mutate it into health promotion, ultimately furthering co-healthist eugenic projects under the guise of beneficial and necessary social transformation; and 3) HAES provides cathartic community care for those distressed by
(internalized) anti-fatness, particularly people who identify with disordered eating and movement. To address the current gap in research surrounding healthism, I proposed a new feminist-of-colour disability studies-oriented definition, which I coined as co-healthism to mark its co-constitution with, and reinforcement of, interlocking systems of oppression. To lean into the evident potentiality of HAES as a space of healing without allowing for co-healthist domination to continue or leaving the most marginalized behind, I also coined the idea of collective intuitive eating/movement (IE/M). Birthed out of disability justice ideology, this practice is a fattened and cripped version of IE and IM, two core principles of HAES. Collective IE/M is anti-curative imaginary and rooted in cathartic collective care, mutual aid, decolonization, abolition, healing as world-building, and radical solidarity. Instead of focusing on individual behavioural modification, collective IE/M performs disability justice and fat liberationist world-building and capacitates us (as individuals and collectives) to continue this work.

In chapter one, I noted how ASDAH’s definitions and deployment of the HAES framework creates a messy space where the lines between health promotion as eugenics and health promotion as health equity and social justice become blurry. In chapter two, I called for a feminist-of-colour disability studies-oriented expansion of ‘health’ from an embodiment, resource, or capacity to a method or lens capable of elucidating how anti-Blackness, white supremacy, anti-fatness, ableism, colonialism, and neoliberalism mutually reinforce one another to require ‘normal’ (ideal) embodiment as a prerequisite to worth and valued subjecthood. This method can also elucidate how “health promotion” via the perfecting of some bodies and elimination of others is positioned as benevolent and essential to the moral and biological betterment of society. So then, knowing that the
concept of ‘health’ is rooted in eugenics and propagates co-healthism, what happens to “Health” at Every Size or health equity activism? I cannot call for an abandonment of the concept of ‘health’ or say that it will never be anything other than oppressive. Many BIPOC peoples have always had non-oppressive understandings of health, both pre-colonization and in the present moment. Under their new leadership team, ASDAH’s definition of health as a resource or capacity that exists on a continuum and not a moral imperative (ASDAH, n.d.-c) exemplifies a non-oppressive framing of health. However, my research shows that health is frequently deployed as a weapon to prescribe value to some bodies and eradication for others.

At the same time, as I have said repeatedly, people need care, and this includes allopathic medicine and formal healthcare. Some people also want and are able to participate in behaviours that may improve their biomarkers of health and reduce disease risk (although I hope by this point, I do not have to remind anyone that health is largely politically, socially, and environmentally determined). People who desire these practices deserve ways of doing them that do not cause physical and emotional distress. We should be able to access these things as fat people. We deserve quality healthcare. We also deserve redress from fatmisia and communities of care where we can support one another in eating and moving autonomously in ways that nourish and capacitate us. HAES is doing the work of fighting for these causes. It has made strides. But it is not enough. It is also actively harming people.

When I attempted to heal from food, exercise, weight preoccupation, and internalized fatmisia utilizing a HAES framework, I did experience visceral relief, joy, and what felt like freedom, at least for a while. But even for myself, with all of the
privilege I have, I could not abolish the fatmisia living within me while the fatmisia around me raged on, especially not on my own, focusing on individual behaviours and thought patterns. I needed fat liberationist and disability justice community and collective action. Even still, while I now truly love myself, nourish myself abundantly, only move to the degree I desire and in ways I enjoy, and see myself as inherently whole, I cannot say I have fully abolished my internalized anti-fatness, emotional distress, or fear of anti-fat violence. The latter could only be fulfilled in a world where global oppressive systems, ideologies, and cultures have been abolished. We are fighting for this world. But people also need care in the here and now. This sparked the idea for collective IE/M because it is a framework for care, healing, wellness capacitation, and abolitionist world-building; it is prefigurative politics, and this idea was born partly from HAES discourse. HAES discourse is full of potentialities, but it is also full of discursive violence.

Thus, my conclusion about the future of HAES is nuanced. There is a complexity to my conclusion that HAES needs to shift to centre care rather than health because HAES was survival for me and many others. Taking something that helps people survive and critiquing it is hard. I feel grief coming to terms with how I have become disillusioned with the framework that first brought me redress from a life largely marked with restriction, self-hatred, and pain. I do not know if I would be where I am in terms of my wellness, purpose, and politics without HAES. This study has shown me how many people it has helped. At the same time, it has solidified my understanding of how easily it can be taken up in service of maintaining a hegemonic social script and social hierarchies that mark deviant bodies for subjugation and death. HAES may have largely worked for me, but this research has allowed me to understand that it is because of my privilege as a
white settler woman on the smaller end of the fat spectrum. Because of the nuances of
HAES’ liberatory potential, paired with the knowledge that it engenders co-healthist
domination, cooptation, and mutation, I must utilize a decolonial both/and (Hunt &
Holmes, 2015) paradigm for my conclusion on the future of HAES. I believe that the
framework both needs to be expanded and abandoned. It is time to move on, but not time
to give up. There needs to be a shift from health to care.

As I have shown in chapter two, the invocation of the importance of ‘good’ health
is ubiquitous, not only in the general public but in HAES discourse itself. The power of
co-healthism lies in the discursive power of anti-Blackness, white supremacy, anti-
fatness, ableism, colonialism, and neoliberalism to mutually reinforce one another and
require ‘health’ (ideal embodiment) as an individual imperative and prerequisite to valued
subjecthood; and prescribe “health promotion” via the perfection of some bodies and
elimination of others; both of which are positioned as essential to the moral and
biological betterment of society. Pragmatically, I do not think even the best iteration and
definition of HAES could adequately challenge co-healthism because the language of
“health” at every size and the aggregation of health enhancement and social justice
allows it to be coopted in service of co-healthism too easily. It has been coopted. We need
to move on. But that does not mean we must give up on the potentialities that HAES has
cultivated or the desire for a world where all fat people have access to healthcare, well-
being, healing, and wellness-capacitating environments.

I have demonstrated a both/and approach to addressing the dilemma of HAES
through my iteration of collective IE/M. But what about HAES more broadly? To clarify
one final time, I am not calling for an abandonment of wellness seeking, formal
healthcare, self-care, individual health-promoting behaviours, or seeking relief from pain and distress. I am calling for a feminist-of-colour disability studies-oriented expansion of what these practices look like. One thing that HAES supporters could do is flip to “Healthcare at Every Size.” More broadly though, through my analyses I conclude that it would be much more potentiating to move towards “Care at Every Size” (CAES). I cannot say what this framework would consist of entirely as this primarily needs to be a collective action. However, my prototype for collective IE/M could be a springboard for thinking about how to articulate this framework. The language of CAES allows the movement to propagate mutual aid and cathartic collective care. It allows it to centre disability justice ideology and abolitionist world-building, thereby enabling fat liberation. Care includes healthcare, collective care, and community care, allowing for the framework to address the need for quality and fat inclusive healthcare without locking the framework in a colonial biomedical paradigm that precludes systems-level analyses that truly benefit marginalized peoples. It addresses peoples’ needs for care, formal healthcare and otherwise; validates peoples’ desires for wellness, healing, and well-being but sees disability and fatness as desirable for the future; and allows for action regarding how peoples’ well-being is largely politically, socially, and environmentally influenced. CAES also does not discursively welcome co-healthist domination or eugenic projects since it addresses capacititating people’s wellness but decentralizes ‘health,’ which can too easily be deployed as a weapon against people. While the idea that fatness is not causally correlated with poor health is still controversial, focusing on this misses the point that health should not be a prerequisite to worth. CAES can challenge the idea that fatness is pathological while centring the inherent wholeness and value of all bodyminds.
Of course, as I mentioned about ‘healing’ in chapter three, the language of ‘care’ is not immune to cooptation. I cannot guarantee the efficacy of a CAES framework. But part of effective organizing is evaluating our strategies and constantly looking to grow rather than being uncritically attached to our current way of doing things. One thing that I can say for certain is that HAES needs radical reimagination, which I have tried to do here. It needs to come back entirely renewed if it is going to be capable of enacting meaningful social change and avoid allowing co-healthist domination. So, bereaved, I am letting go of HAES, or at least the aspects of it that do not work. I am dreaming of a CAES framework that capacitates wellness and healing for all bodyminds. Finally, I am welcoming anyone who wants to join me.
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