

A Black Feminist's Critique of the Crooked Room of Medicine (CRoM): Innovation of Thick
Studies and the Gender, Race, Weight (GRW) Matrix

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ABSTRACT

First described by physician William Dietz in 1995, the “Food Insecurity-Obesity Paradox” (FIOP) attempts to explain the biology and behaviors of people who are simultaneously overweight and food-insecure. I was introduced to this theory as a Behavioral Health graduate student and, in that context, was taught to understand it as a fact. My personal experiences as a Black woman, however, alongside ongoing engagement with Black feminist thought and critical medical sociology, have taught me otherwise. This dissertation takes Dietz’s theory as a starting point in order to argue that Black women in the US experience fatphobic and racial discrimination while being “cared for” by western institutional medicine. I argue that discourses like the FIOP, though framed as benevolent clinical theories, do more harm than good: not only do they multiply pathologize so-called “fat” Black women by drawing on disparaging stereotypes, but they simultaneously *ignore* the specific health and wellness needs that emerge at the intersection of weight, size, skin color, gender, ability, and economic class.

My broader dissertation project is an interdisciplinary critique of pathologizing discourses about Black women, including medically “legitimate” ones like the FIOP. Via critical analysis of these discourses, and employing Black feminist and medical sociological perspectives, I explore how stereotypes of Black women correlate with how these women are perceived and treated by physicians and other health professionals. These racialized perceptions and forms of discriminatory medical treatment are instances of what has been labeled, variously, as a racial formation (Omi and Winant, 1997), a matrix of domination (Patricia Hill Collins, 1990) and a racial ideology (Feagin, 2006). These processes are further extended by physicians who use these pathologizing discourses and practices to advance their own careers. Black feminist theorists have described the multiple marginalizations experienced by contemporary Black women in the US and my project places weight and body size within this marginalizing dynamic. After tracing the long history of medical “othering” of Black women by science, I show the persistence of these ideologies in contemporary medical practice. My interviews with Black women investigate their lived experiences of these ideologies and practices, and allow women to speak for themselves in a space that so often speaks for them.

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GENERAL AUDIENCE ABSTRACT

Black women's historical experiences in the US, including my own story, are akin to what Black feminist Melissa Harris-Perry in her book, *Sister Citizen: Shame, Stereotypes, and Black Women in America* (2011), calls the crooked room. Applying Harris-Perry's theorization of the crooked room to how medical institutions operate to cause Black thick women to be so quickly categorized as diseased, I have developed the concept of the Crooked Room of Medicine (CRoM) to describe the mental, emotional, and physical struggles Black women face at the intersection of race and gender stereotypes and false narratives particularly in medical settings.

I utilize and build upon Black feminist theoretical frameworks as well as my own personal narrative to investigate how a society that is built on racialized and gendered systems has implications for how the large Black female body is interpreted as unhealthy and diseased when treated within these social and medical settings. Building on Tressie McMillan Cottom's scholarship, I utilize a methodology of what I call Thick Studies to develop a Gender Race Weight (GRW) matrix from the crooked room of medicine, to map out our experiences and develop a theory that focuses on healing. The result of Black women's disproportionately poor health outcomes is a result of a complex environment of barriers from quality health care, to racism, and stress correlated with the distinct social experiences of Black womanhood in U.S. society (Chinn. Martin, Redmond 2021). The heaviness of generational racialized trauma is still in our DNA (Degruy-Leary 2017). Racism and gender discrimination have profound impacts on the well-being of Black women. I argue for a holistic health treatment that addresses mind, body, emotion, and spirit and for an acknowledgement of Black women's knowledge of health and healing in relation to Black women, weight, and medical space.

Dedication

To my grandfather, Archie Lee Newton, my “Papo,” who would ask me everyday when picking me up from school, “What did you learn today? Make sure you learn something new everyday.”

I hope you are proud Papo. To my grandmother, Ruth D. Newton, thank you, I love you.

To Ms. Tracy Espinoza and other Black women that we may not know the names of who have suffered from the CRoM, we love you all, known and unknown.

This dissertation is also dedicated to the amazing women who participated in this work. Thank you for sharing your stories and being so open and vulnerable to share your stories to the world. May this show you your power and awesomeness!

To single-mothers everywhere...Keep ya head up! (Shakur, 1993)

And to my daughter, ZhaKari Aariah Strange, you are beautiful, amazing, and a light! Thank you for teaching Mommy new things everyday. I love you! This is for you!

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I would first like to thank God and the Holy Spirit!

This dissertation would not be possible if it were not for the help of my amazing committee. Dr. Andrea N. Baldwin, words cannot express how my heart is filled with thankfulness for you.

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To my mother, Judith M. Newton, thank you for your sacrifices, I know it has not been easy being a single mother, without you and all your sacrifices it would not be possible for me to be in this position. The foundation you laid for me and the introduction to God as the starting point of life to get more in touch with myself and the divine has taken me a lot of places to carry my purpose through.

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I love black women.

I love the Baptist church mothers in white.

I love the YouTube twerkers.

I love the sisters with Ivy League degrees and the ones with GEDs.

I love the big mamas, ma'dears, and aunties.

I love the loc-wearing sisters who smell like shea butter.

I love the ladies of the “Divine Nine.”

I love the “bad bitches” in designer pumps and premium lacefronts.

I love the girls who jumped double Dutch and played hopscotch.

I love the Nam-myoho-renge-kyo chanters, the seekers, and the atheists.

I love the awkward black girls and the quirky black girls and the black girls who listen to punk.

I love the “standing at the bus stop, sucking on a lollipop” ’round the way girls.

Black womanhood—with its unique histories and experiences—marks its possessors as something special.

I love black women, and I want the world to love black women, too.

-The Sisters Are Alright: Changing the Broken Narrative of Black Women in America, Tamara Winfrey-Harris

*“Chocolate b**** super THICK in a camouflage thong” -Young Dolph & Key Glock, “Water on Water on Water”*

“I’m his favorite type of chick, boujee, bad, and Thick” -Cardi B & YG, “She Bad”

Introduction

In 1995, a doctor named William Dietz (1995) published the results of a case study featuring an “obese” seven-year-old African American girl who was living in a single female-headed household that consistently lacked adequate resources for food. This encounter led Dietz to speculate about a relationship between observable rises in “obesity” and in hunger (Dietz, 1995). Importantly, however, the child’s blood pressure was noted to be “normal... [and a]side from her obesity, the remainder of [her] physical examination was unremarkable. A urinalysis showed no glucosuria” (Dietz, 1995, p. 766). Glucosuria, a medical term for excessive sugar in the urine, is most often caused by elevated blood glucose levels, which are typically due to untreated diabetes mellitus. Clinically, that is, diabetes and “obesity” are thought to go hand in hand, and glucosuria might have led Dietz to worry that this child’s weight increased her risk for diabetes. But as Dietz himself indicated, aside from her medical “obesity,” the young girl’s exam and general health were “unremarkable” (Dietz,, p. 766).

William Dietz’s labeling of this young Black girl’s body as “obese” reflected his perception of her as diseased, as outside the range of his view of “healthy.” Despite the results of his own physical examination, through which he deemed all but her weight to be “unremarkable,” what Dietz saw and perceived (a young Black, fat/thick girl who he knew to be poor) spoke louder to him than the results of his own tests. William Dietz’s Western Eurocentric view of health interpreted this child’s Black “fat” body and deemed her diseased. Not only did he make this connection (i.e., between race, size, gender, and disease), he made a further connection between her socioeconomic status and her weight, something he defined as the “Hunger-Obesity Paradox,” which evolved into the “Food-Insecurity-Obesity Paradox.” In the published case study, Dietz defines the paradox as follows:

Both hunger and obesity occur with an increased frequency among poorer populations in the United States. Because obesity connotes excessive energy intake, and hunger reflects an inadequate food supply, the increased prevalence of obesity and hunger in the same population seems paradoxical. Although a variety of environmental, social, behavioral, or physiologic mechanisms could cause both problems independently, an alternative possibility is that hunger and obesity are causally related. The following case report supports this hypothesis (p. 766).

This dissertation takes Dietz's pathologization of this young Black girl as its starting point to investigate the consequences of physician bias. Following Dietz, research in the fields of Behavioral Health Science, Nutrition, and Dietetics found that food insecurity and obesity were indeed strongly and positively associated with women of color (Coleman-Jensen et al., 2014; Dietz, 1995; Franklin, 2012; Dinour, 2007; Wilde, 2000; Jilcott et. al., 2011; Papan et. al., 2015). "Low-income, ethnic minority, and female-headed households exhibit the greatest association for food insecurity and obesity" (Franklin et al., 2012). Dr. William Dietz served on the 1995 Dietary Guidelines Advisory Committee, and in 1997, he received the Brock Medal of Excellence in Pediatrics from the New York Academy of Medicine. In 1998, he was elected to the Institute of Medicine of the National Academy of Sciences, and he is the author of more than 200 scientific publications and the editor of five books, including *Clinical Obesity in Adults and Children* (2009, now in its second edition) and *Nutrition: What Every Parent Needs to Know* (2012). Dietz's theory targets Black female-headed households, characterizing them as suffering from a poverty-stricken path that explains the high rates of "overweight," "obesity," "unhealthiness," and the extreme racial "obesity" disparity among Black women from one case study of one young Black girl. Furthermore, his theory contributed to literature and miseducation to the social science health field that contributes to a legacy of mistrust, misdiagnosis, experimentation, and deviant health pathology of Black girls and women.

In the mid-1990s another young Black girl around the age of seven experienced a few trips to the doctor's office. That young girl was me. Since I can remember, "weight" has always been a struggle for me. Growing up, it was just my mother and I. Though I know that had to be very difficult for her, I couldn't have imagined it any other way. She worked a lot, so I was often at my grandparents' house (which, at the time, I wasn't always happy about because I wanted to be with my mom, but now that I'm older and they are no longer here I appreciate that time). I always had everything I needed, including food. I don't recall times of food insecurity (if there was, my mom did a great job of hiding it). She made "too much" money for any federal assistance programs, so I don't recall us ever using any food assistance.

The clearest memory I have about my weight is in doctors' offices when I was a child. I remember being elementary school age having regular checkups. I was always in the doctor's office for my allergies; however, my weight always seemed to be a topic of discussion during doctor visits. I remember the doctor standing there in a long white coat holding up a black-and-white chart with black lines and slopes on it (children's weight chart/BMI calculator). He would draw a thick blue dot way off the chart far away from the rest of the slopes and lines and look at my mom, then look at me and say something to the effect of, "You see this dot right here? This is you; you're way over here, way off the chart." His long speech ended in a physical activity discussion and a "watching what I eat" conversation with my mom. I remember toward the end of those conversations I would be crying. Oftentimes my mom would as well. As mentioned, I don't remember the doctor's words verbatim, but what I do remember is how his words made me feel, a feeling that I still struggle with to this day. That was the first time I remember the feeling of being an "other," not like the rest, "too big," "too much," something that "needs to be fixed, to

be like the rest.” Of course, some kids my age had mean things to say about my weight here and there before that event, but they were kids; they were my age. What did they know?

But that interaction changed the game for me. I believe from then on I paid closer attention to negative things anyone said about my weight: classmates, family members, my mom’s friends, anyone. This encounter intensified my uncertainties. This was a professional, a doctor. He had to be right, right? I remember my mother scrutinizing me “when I ate too much.” I remember being embarrassed to eat around her or anyone. I remember going on a lot of walks and being on “diets” and being restricted from foods at a young age. (This may have foreshadowed moments in my adulthood of binge eating greasy and sugary snacks, then having so much internal guilt, rushing to the nearest toilet to throw up every piece of chunked, swirled sugary snack that I just shoved down my throat.) I remember being teased a lot in elementary and middle school. I grew up in Oxnard, California, and I was often either the only or one of two Black students in my classes. Not only did I stand out for my Blackness, but I was the “fat” dark skinned-girl. I was well aware of stereotypes at an early age. I remember making sure I was always “the nice girl,” always super sweet and smiling. Making sure people saw me as less threatening so I wouldn’t be called “Shanaynay,” or “Aunt Jemima” persistent stereotypes of Black women in the ’90s as loud, “ghetto,” “too much,” and “big.” I was often called those terms anyway.

Anti-Blackness, anti-fatness, and misogynoir were true to my experience growing up in Southern California suburb, which portrays to the world and people living in it that it is the epitome of health, Baywatch beach bodies, and Hollywood dreams. (At least it felt that way in my child mind.) I ran away from California to my HBCU mecca on the East Coast, only to find that

out as I enter my 30s, California, the place that I felt did not welcome my big Black female body, was named after a “robust” Black woman, Queen Califia¹.

Importance of the study

My lived experience aligns with that of Dietz’s patient. Black adult women in the U.S. live the legacy of this medical encounter (between Dietz and the young girl) and how it is an example of how Black women have occupied bodies deemed/labeled excessive, diseased, “out of control,” “too much” in the U.S. for centuries. Black bodies have historically been pathologized as deviant in health and medical fields (Washington, 2016; Hogarth, 2017; Driggers, 2019). This cycle is not only problematic for the mental and physical health of the individual but also for any real and true efforts of closing racialized health disparity gaps. “Fatness” is not a characteristic of

¹ Writer and activist of the African Diaspora, Bridgett Boakye in her March 24, 2019 article in *Face 2 Face Africa* “You probably didn’t know that California was named after a black queen” writes, Montalvo’s Island of California was named after its Queen, Califia, who is said to have been a beautiful Black Moor and pagan. She writes that this island was populated by Black women who lived in the way of the Amazons. They had beautiful and robust bodies and were brave and very strong. It was said that Queen Califia captured the imagination of many around the world, especially that of Spanish explorer Hernán Cortés, who would come to explore and name the state California. Historian John William Templeton writes that “Califia is a part of California history, and she also reinforces the fact that when Cortés named this place California, he had 300 black people with him.” (2019). Famed African-American actress Whoopi Goldberg depicted Queen Califia in the Disney film *Golden Dreams* (2001). There is a seven-foot-high panel of Califia with her Amazons at the Mark Hopkins Intercontinental Hotel in San Francisco. There is also another depiction of Califia on the fourth floor in the Senate Rules Committee Hearing Chamber in Sacramento titled “The Naming of California.” To be a thick Black woman who grew up in California and not know this history has been wounding on so many levels.

Blackness. Until Blackness and the negative connotations of “fatness” are seen separately, continued stereotypes, ideologies, beliefs, and prejudices will impact our very existence. This project utilizes Black feminisms and medical sociology to debunk false and deficit narratives of Black women. This project also engages with and critiques Fat Studies to highlight physician and medical bias, while also utilizing Black feminisms to critique Fat studies.

The issue with Dietz’s paradox is that it operates under and within false, deficit, and misinformed notions of “fatness” and “Blackness” and stereotypes of government dependence. The paradox further medicalizes and pathologizes Blackness as deviance and “fatness” in Black women as something that needs to be cured or fixed. The deficit paradox also operates under the false notions and stereotypes of “welfare queens” by implying that poor Black single mothers on government assistance, which most single Black mothers do not even qualify for (Washington, 2006) have a path and legacy of a cycle of insufficient resources to feed their children. This explains high “obesity” rates of Black women and girls and therefore because they are “obese” or “overweight” they live a life of further disease and illness. This paradox is applied within social health science interventions and is extremely problematic and harmful to Black lives.

Research Information and Questions

In this project I ask the following questions:

- 1) What are Black women’s experiences around health, race, and body size?
- 2) How are these experiences influenced by
 - a) intimate household settings,
 - b) community settings,
 - c) social/medical settings

- 3) How have these experiences impacted Black women's self-perception, and how they navigate society including
- a) intimate household settings,
 - b) community settings,
 - c) social/medical settings

To answer this question, I developed a Gender Race Weight (GRW) matrix. (see **Appendix C**)

Theoretical Framework

I use Black feminist and medical sociology frameworks to guide this project. Guiding this study is scholarship by Patricia Hill Collins on Black feminist thought and the matrix of domination, Mikki Kendall's Hood feminisms, Melissa Harris Perry's crooked room theory, Kimberle Crenshaw's intersectionality, Moya Bailey's misogynoir, Tressie Cottom's "thick"/Fat studies.

Black feminism provides Black women space to bring their life experiences and knowledge to the forefront. There is knowledge in Black women's experiences. Black feminist thought (Collins, 1990) suggests that through Black women's unique positionality they developed alternative forms of knowledge. Black women have been positioned to create independent, oppositional yet subjugated knowledges concerning their own subordination, and Black feminist thought privileges the voices of the marginalized (Collins, 2000). In Jennifer Nash's (2018) definition of Black feminisms she states,

"I treat black feminism as a varied project with theoretical, political, activist intellectual, erotic, ethical, and creative dimensions; black feminisms is multiple, myriad, shifting, and

unfolding. To speak of it in the singular is always to reduce its complexity, to neglect its internal debates and its rich and varied approaches to questions of Black women's personhood. I treat the word 'black' in front of 'feminism' not as a marker of identity but as a political category, and I understand a 'black feminist' approach to be one that centers analyses of racialized sexism and homophobia, and foregrounds black women as intellectual producers, as creative agents, as political subjects, and as 'freedom dreamers' even as the content and counters of those dreams vary" (p. 5).

The purpose of this project is to engage in, challenge, and build on Black feminisms around the issues of Black women that have bigger bodies. Black feminist scholars have provided a historical analysis about how Black women's bodies have been objectified and oppressed (Spillers, 1994; Harris-Perry, 2011; Benjamin, 2020; Ritchie, 2012; Strings, 2019); however, there is a lack of interrogation of Black women with bigger bodies. The scholarship that has done that work to my satisfaction thus far include Tressie McMillian Cottom's *Thick: and Other Essays* (2018) and Andrea Elizabeth Shaw's *The Embodiment of disobedience: Fat black women's unruly political bodies* (2006). Scholarship which interrogates the lived realities of people with "bigger" bodies is found in the field of Fat Studies; which I will be pulling from and critiquing throughout this dissertation. As a Black "thick" woman, I am hesitant engaging with Fat Studies because it appears to be a field which tends to center whiteness . As such, I have developed a theory that examines the lives of thick Black women, creating a Gender, Race, Weight matrix (GRW) inspired by the Violence Matrix Beth Ritchie's outlines in her 2012 book, *Arrested Justice: Black Women, Violence, and America's Prison Nation*.

Fat Studies literature has historically been written by white Fat Studies and feminist scholars who have largely ignored Black "fat" women's bodies. To date, the literature on Black "fat" bodies has been largely about the mammification of Black "fat" women's bodies as big-breasted nurturers, and asexual property and how they have never been seen as beautiful or worth admiration in society (Collins, 1991; Spillers, 1994; Harris-Perry, 2011). There is a discomfort

that sits with me not only as a Black woman, but also an extreme discomfort with the apparent disconnect between the two disciplines not talking to each other. Building on Shaw's work (2017), Black "fat" women's bodies have always been seen as "unruly," "out of place," worthy of rejection and dehumanization, and there is a glaring absence of discussion of these bodies in the Fat studies literature.

Black feminisms therefore frame the ways in which I think of Black thick bodies. However, I also have an internal debate with Black feminisms' seeming lack of interrogation of Black women with bigger bodies and lack of addressing "fatness" in depth within the discipline. Because of this lack of interrogation I will draw out some frameworks from Black feminisms, but my contribution to this knowledge will also draw from medical sociology and Fat Studies. As Nash defines Black feminisms (2019), my project is rich and varied, utilizing multiple approaches to Black feminisms: Melissia Harris Perry's crooked room theory (2011), Tressie Cottom's Thick theory (2019), and Beth Ritchie's matrix (2012). I am utilizing all of these concepts because they are multiple and varied approaches to questioning and unfolding the social and medical experiences of gender, race, and weight as it pertains to Black women and girls. I insert my own experience not only as a Black feminist approach and methodology, but as a creative and agentic exercise as a "freedom dreamer" (Nash, 2019). I advocate for the freedom of Black women in "bigger" bodies who do not find themselves stuck in the term "fat" as it is defined and theorized by fat studies scholars, and who are also living with the ways in which society stereotypes our Blackness, our thickness (Cottom, 2019), and our "unruly" bodies (Shaw, 2006), causing us to feel a certain discontent in the way we exist.

By examining health literature and medical information, such as the Food Insecurity-Obesity paradox (FIOP), through a Black feminist, medical sociology, and Fat Studies approach,

this study will explore how stereotypes of Black women directly relate to how the medical settings, professionals, and rhetoric contribute to the misdiagnosing, misunderstandings, and medical treatment of our bodies. Resulting in not only the under- and misdiagnosing of Black women patients, but also our self-perception and internalized generational patterns and behaviors. These negative labels and physician bias also contribute to racialized health disparities.

Because of race science, white supremacy, racism, misogynoir, economic prejudice and stereotypes, Black women are continually given the message that they are, in general, an “unhealthy” population, more prone to disease, and that their bodies are suffering from a medical condition that they should and need to fix. This burden comes with impact. The purpose of this project is to investigate the intersecting gender, race, and weight experiences of Black women as they are experienced in medical and social settings. My first recollected intersecting experience of my gender, race, and weight was at the doctor’s office and othered by being placed “off the charts,” then walking back into society with the same perception of how to see myself. I know that I am not the only Black woman/girl that has felt this way, and so I want to tell our stories. According to Black feminist philosopher Sylvia Wynter (2003), Black women have historically been dehumanized, unseen, and unheard especially as subjects in the institution of medicine (Roberts, 1999; Washington, 2006; Bridges, 2011; Axelsen, 2012; Davis, 2018).

“Fat” Studies scholar and author of *Fat Studies: An Invitation to Revolution* (2009) Marilyn Wann states that “it will require the work of many Fat studies scholars to fully trace all the harm caused by use of the term ‘obesity’ (including belittling assumptions, internalized oppression, discriminatory consequences, and more)” (p. xiii). Wann emphasizes the harm done to those labeled “obese.” I know how that harm feels and the impact it can have on a person.

Feminist and “fat” studies scholar Laura Brown (1989) highlights how living in a “fat”-phobic society creates oppressive treatment, therefore creating a “fat” oppressed identity that perpetuates self-hate and pain. These social ideologies carry extremely negative and harmful effects and impact on individuals living and existing with “fat” oppressed identities. Brown states, “There are few girls and women of any age or culture raised in white America, who do not have some manifestation of the concerns...distortion of body image, a sense of ‘out-of-control’ in relationship to food, addiction to dieting, bingeing, or self-starvation...I hesitate, as a feminist, to see it as a form of true internal psychopathology. It is, however, a serious source of pain and self-deprecation for women...” (1989, p. 61). That is why I want to provide space for those who have been harmed or know someone who has been harmed by racially contoured fatphobia. By utilizing Black feminisms and Fat studies frameworks, this study will provide space for Black women who have been harmed by the label of “obese,” “overweight,” and/or “off the charts.”

This study will explore how a society that is built on racialized and gendered systems has implications for how the Black female body is interpreted as unhealthy and diseased by social and medical professionals, and how that body is then treated throughout social and medical settings. There are many recommendations and efforts to bridge the Black/white health disparities gap, especially “obesity.” Black feminists and fat studies literature also suggest that until health and medical professionals work outside of the realm of the U.S.’s historical colonial capitalist structure with its associated racist, classist, patriarchal systems, Black women will always fall into the category of unhealthy and diseased, and the gap will never close.

Thick Studies

I propose, based on reviewing the literature, to engage in what I am calling “Thick Studies,” which borrows from, critiques, and develops the work of Tressie McMillan Cottom. In her 2019 text *Thick: and Other Essays*, Cottom engages in levels of thick analysis and how the term “thick” kept showing up for her as a Black woman, not only just in terms of her physicality but even her thinking and writing as an academic. Cottom states, “My writing has a high body count, as the kids say” (p. 27). This connection is not just to the actual word-processing analysis count of her writing. Her quote also speaks to Black female sexuality and the reclaiming of the “welfare queen” and “jezebel” tropes.

A Thick analysis, therefore, acknowledges and celebrates the shifting and unfolding of Black feminine sexuality agency in a society that frowns upon and inflicts reproductive and social violence on Black women with a “high body count,” that is, Black women who unapologetically reclaim and embrace their sexuality without regard to the negative stereotypes society attaches to their bodies (Roberts, 1999; Washington, 2006). A thick analysis provides space to examine how Black women historically and contemporarily have rejected the negative connotations associated with tropes applied to Black women and their bodies as well as reclaimed those tropes for their own use. This includes the welfare queen trope and notions of Black women being dependent on food stamps, wearing long weaves and engaging in so-called “ghetto” culture (Hannerz, 1969) and the jezebel trope used to enact violence on Black women who embrace their Black female sexuality (Collins, 2004), including those women with bigger bodies. My analysis sees Black culture as rich and thick in the way that Carole Boyce Davies writes in her 2002 book *Black Women, Writing and Identity: Migrations of the Subject*. She quotes Charles Nero to identify aspects of Black culture that are normally seen in a negative light but which should be celebrated — “capping, loud-talking, the dozens, reading, going off, talking smart, sounding, joining

(jonesing), dropping lugs, snapping, woofing, styling out, and calling out of one's name" (p. 230). All these ways of reading and engaging with Black culture are thick and often directed at dismantling dominant or pretentious discourses around Black people, our bodies, and our lived experiences. A Thick analysis functions similar to Nash's definition of Black feminisms, shifting, unfolding and unpacking the notion of living in the complexities of gender and race, and now the added analysis of weight. A thick analysis takes a deeper and more complex interrogation of marginalized categorization. I can embrace "ghetto" culture, listen to trap music, have a high body count, as well as be an intellectual and wealthy all at the same time. I can be and do all these things and still be a complex and deep thinker, not fitting into societal boxes, "oozing out" because a thick analysis/study oozes out and embraces complexities.

Crooked Room of Medicine (CRoM)

In this project I also introduce the crooked room of medicine (CRoM). Developed from Black feminist political scientist Melissa Harris-Perry and her 2011 book *Sister Citizen: Shame, Stereotypes, and Black Women in America*, I work with and build on the theory of the crooked room. CRoM highlights the historical dehumanized medical treatment of Black women's bodies that has impacted their contemporary health and treatment. CRoM produces conditions that continue to cause Black women to feel bad about themselves and their bodies. This stems from a history of how Black women have been dehumanized generally and in the medical field of which Dietz is a significant part; this is why the opening encounter between him and the young Black girl is an important example. To escape this room and for Black women to feel better and to be treated better, it has to be critiqued and dismantled. This project engages in this critique through the (GRW) matrix —part of my Thick methodology — which I will pilot with a series of interviews. My project also does this by developing a healing theory, Thick Studies, where Black

women can see themselves and are not beholden to the deficit narrative of the Food Insecurity-Obesity Paradox and any other narrative of CRoM.

Lastly, I argue for holistic health approaches and treatment for Black women's health: the idea that each human being is composed of physical, mental, emotional, and spiritual dimensions (Lawrence, 1998; Iqbal, 2013). As theorized by Harris-Perry (2011), the crooked room affects physical, emotional, mental, and spiritual aspects of Black womanhood, as well as inflicts shame, the internalization of the crooked room(s). Therefore, holism addresses all aspects of the crooked room and should be used as a foundational approach for Black women's health.

Terminology

A brief note about terminology. Throughout this work I will be putting the words “overweight” and “obesity” in quotations because they connote disease to many and are perceived to carry stigma to people that are not thin; these words also medicalize human diversity (Wann, 2009). The terms “fat” and “fatness” will also be in quotations. The term “fat” is used by many fat-positive scholars and activists in an effort to reclaim the word and combat stigma; however, some people reject those terms as well, and I want to respect that. The intent of this project is not to offend anyone, but to uplift and provide perspective for those who reject these terms. By putting these words in quotation marks, I am asserting power back to those who have been wrongly labeled, described, or who just don't identify with words that are oppressive and meant to categorize; people should have the power to identify themselves and not have to pick a category.

The words “healthy” and “unhealthy” will also be in quotations because the measure of health differs from body to body; there is no true measure of health. Bailey (2017) states, “Health

is both a desired state of being and a social construct necessary of interrogation because race, gender, ablebodiedness, and other aspects of cultural production profoundly shape our notions of what is healthy”(p. 2). U.S. society’s definition of health is another example of the crooked room as far as medical terminology because there is no clear, real, and true definition of health. I consider myself healthy, but if I walked into a medical office right now, they would label me “obese” and therefore diseased. In U.S. society health is based on appearance. Metzel and Kirkland continue to affirm that, “‘health’ is a term replete with value, judgements, hierarchies, and blind assumptions that speak as much about power and privilege as they do about well-being. Health is a desired state, but it is also a prescribed state and an ideological position. It will not take much browsing time to realize that these publications share the common assumption that health is ultimately defined by a person’s appearance” (2010, 1–2).

The literature that was reviewed for the purpose of this research used “Black” and “African American” interchangeably, so I will follow that format. I also capitalize “Black” to distinguish between Black as a cultural group as opposed to a skin color. “Blacks, like Asians, Latinos, and other ‘minorities,’ constitute a specific cultural group and require denotation as a proper noun” (Crenshaw, 1988). Not all literature capitalizes the “B” in Black. Also, I use the words ‘female’ and ‘woman,’ ‘women’ interchangeably as it is reflected in the health literature ‘female’ is used to express gender while Sociology and Women and Gender Studies use variation women, woman, and womxn for inclusional purposes. I use these variations interchangeably as I move across disciplines in this dissertation with no intention to offend any gender identity.

Chapter I

Literature Review

Black Feminisms

In this chapter, I begin by examining several theoretical frameworks as well as conduct a review of Black feminist literature in relation to medicine and the body. I follow this by discussing what I have termed the “crooked room of medicine (CroM),” and I conclude this section by looking at some of the ways that medicine and public health have both understood and attempted to explain Black women’s physical and mental health. I utilize Black feminisms to build my theory of the CRoM making a scholarly contribution to its seeming lack of interrogation of Black women with bigger bodies. I also engage Black feminisms to critique Fat studies, to develop a Black feminist theory that examines the lives of Black thick women, which I define to be Thick Studies, using the Gender, Race, Weight (GRW) matrix.

I employ Black feminist thought as a theoretical framework in this project because it centers and theorizes Black women’s social experience, which has been marginalized along multiple lines, including race and gender (Collins, 1990). “Black feminist thought demonstrates Black women’s emerging power as agents of knowledge. By portraying African American women as self-defined, self-reliant individuals confronting race, gender, and class oppression, Afrocentric feminist thought speaks to the importance of that oppression, Afrocentric feminist thought speaks to the importance that knowledge plays in empowering oppressed people” (p. 553). There is knowledge from Black women’s experiences; there is unique knowledge that can be obtained from doctors and professionals of a similar race who can relate with their patients from similar circumstances. But until Black people are affirmed in personhood, knowledge bases,

and in their humanity, rather than seen as just bodies that need to be fixed, othered or studied, disparity gaps will not close. I'm using weight and size around Black women's health care experiences to make this point. My contribution to this literature is the conversation of weight and size as it pertains to Black women's medical experience. My contribution is also in my extension of Black Feminisms, Thick Studies, the GRW matrix and CRoM because it is more than just Black women and girls medicalized experiences, it's about seeing Black women and girls beyond their medicalized experiences. Utilizing Dietz's encounter with the seven-year-old Black girl and his test results' indication of her healthy body, Dietz deemed her "obese" and unhealthy, pathologizing her healthy body due to her weight. This initial encounter furthered his career. By employing Black feminist thought I will place this seven-year-old Black girl's experience rather than Dietz's test result that indicated a healthy body at the center of analysis to offer fresh insight as to why her weight and size was his focus.

I also employ Patricia Hill Collins' 1990 matrix of domination theory. Matrix of domination is a theoretical approach that explores the interlocking systems of oppression in terms of race, gender, class, and other social categories; it theorizes power in four domains: structural, disciplinary, hemogenic, and interpersonal. The Matrix of domination provides a multidimensional look into oppressed experiences that Black women face. I am adding the contribution of weight and size to the research and discussion of Black women's health experiences.

Collins (1990) asserts that "knowledge is a vitally important part of the social relations of domination and resistance. By objectifying African American women and recasting our experiences to serve the interests of elite white men, much of the Eurocentric masculinist worldview fosters Black women's subordination. But by placing Black women's experiences at

the center of analysis offers fresh insights on the prevailing concepts, paradigms, and epistemologies of this world view and on its feminist and Afrocentric critiques” (p. 553). A Black feminist perspective brings to the project voices that are often silenced, particularly regarding their own bodies. Black women have historically been dehumanized, unseen, unheard, and subjects in the institution of medicine (Spillers, 1994; Wynter, 2003; Washington, 2006). In direct contrast to this silence, a Black feminist framework highlights Black women’s experiences as knowledge and also explains why those experiences have never been heard. Black feminisms centers the experiences of people like me and the seven-year-old healthy girl who was, by Dietz’s examination, diseased.

Black women continue to experience higher mortality, shorter life expectancies, and higher rates of maternal mortality (CDC: Chinn, Martin & Redmond, 2021). Moreover, Black women are disproportionately burdened by chronic conditions such as anemia, cardiovascular disease (CVD), and “obesity” (Chinn, Martin & Redmond, 2021). “These health disparities are in large part a reflection of the inequalities experienced by Black women on a host of social and economic measures” (Chinn, 2021). This study focuses on the so-called “obesity” health disparity as it pertains to Black women’s health. “No discussion of health equity among Black women is complete unless it considers the impacts of institutional- and individual-level forms of racism and discrimination against Black people” (212).

This study focuses on the individual encounter with Dietz and the seven-year-old Black girl. However, it also uses that encounter to highlight how Black women and girls’ individual racialized encounters within medical space contributes to institutional racism and discrimination in regard to health. The matrix of domination also explicitly addresses economic and political aspects and how they work. “One distinguishing feature of Black feminist thought is its insistence

that both the changed consciousness of individuals and the social transformation of political and economic institutions constitute essential ingredients for social change. New knowledge is important for both dimensions of change” (Collins, 553).

“The health of Black women is measured in their disproportionately poor health outcomes, but it is a result of a complex milieu of barriers to quality health care, racism, and stress associated with the distinct social experiences of Black womanhood in U.S. society” (Chinn, 2021). Without a Black feminist perspective and the knowledge regarding our own health and medical sociological statistics there would be no change regarding contemporary Western medical practices in regards to Black women’s health “disparities” and the Black-white health gap.

Patricia Hill Collins’ (1990) concept of the matrix of domination refers to wider contexts and patterns, describing an “overall social organization within which intersecting oppressions originate, develop, and are contained” (pp. 227–228). This concept helps us to understand how gendered and racialized rhetoric is continued throughout society and sustained. Racialized ideologies and racial frames maintain this structure. A racial ideology can be regarded as a normalized ideological framework that is adaptable enough to adjust to the justification requirements of the dominant white society. Clarified in the words of Feagin (2006), a strong racial ideology is the “set of ideas and notions defending white power and privilege as meritorious and natural and accenting the alleged superiority of whites and the inferiority of those who are racially oppressed” (p. 28). This is also critical to the white racial frame that maintains this structure. According to Feagin, the white racial frame “is an organized set of racialized ideas, stereotypes, emotions, and inclinations to discriminate. This white racial frame generates closely associated, recurring, and habitual discriminatory actions. The frame and associated discriminatory actions are consciously or unconsciously expressed in the routine operation of

racist institutions of this society... [which] has been maintained, albeit with some reworking, to the present day” (p. 25).

The matrix of domination further explains that there are racialized and gendered beliefs, ideas, and stereotypes that then turn into recurring practices and actions that maintain and reinforce a hierarchical dominance throughout society and time, while at the same time maintaining oppressive patterns, practices and behaviors that harm and erase the nondominant group. Based on this hierarchy, white males are at the top and Black women and girls are not. Stereotypes have historically been the driving force and justification of treatment and judgment of Black women’s bodies throughout society. Reinforcing a dominant white male society, this hierarchy creates power dynamics, pushing more power to white males and less power to those below them. Those that benefit from these social reinforcements often feel as though they have authority over those below them in the hierarchy. White males have been the writers of history, knowledge, and education. This hierarchy removes, silences, marginalizes, and erases people from history. This hierarchy removes, silences and erases spaces for others to tell their own perspective of history. Black feminisms allow space for Black women’s knowledges, experiences, pedagogies, and practices, for us to be the writers of our own stories and gain power through this space (Minor, 2012).

In her 2011 book *Sister Citizen: Shame, Stereotypes, and Black Women in America*, Black feminist political scientist Melissa Harris-Perry introduces the crooked room theory. She writes, “African American women are standing in a room skewed by stereotypes that deny their humanity and distort them into ugly caricatures of their true selves. As they struggle to find the upright in this crooked room, they are beset by the emotional, physiological, and political consequences of race and gender shaming. This shaming has tangible, even disastrous

consequence...” (p. 29). This quote is powerful in detailing the multilayered and complex external and internal battles of Black womanhood, expressing the mental, emotional, and physical harm and consequences of navigating crooked rooms. I believe physical and mental consequences are clear when we look at Black-white health disparity statistics. Harris-Perry documents various psychological studies of tainted perceptions and decision-making that can arise in these metaphorical unevenly shaped environments; she then uses them to illuminate the struggles Black women face at the intersection of race and gender stereotypes and the mental and physical struggles that affect our health from these crooked rooms. “Hateful stereotypes are the tools that build the crooked room” (p. 49). Stereotypes such as “the welfare queen,” “the mammy,” and the deviant “jezebel” that I will be exploring in this project. These environments/ “crooked rooms” symbolize an unequal playing field where misrepresentation or invisibility erases the contributions of Black women’s history to the success of the nation And erases their own experiences — hence Dietz was able to make inferences about his patient, thus instead of Black women telling their own stories, his myth became the pervasive ‘story’ about Black women.

Harris-Perry explores the complicated cultural myth of “the strong black woman” and “the angry black woman,” exposing the mental and emotional consequential impact that these stereotypes have on Black women (p. 215). The layer of the connection between Black women and faith/spirituality is not often discussed in regard to health; however, Harris-Perry discusses faith in a way that is often a vehicle in how Black women navigate stressful structural circumstances. Unfortunately, oftentimes faith is also a crooked room for Black women, pulling from patriarchal forms of Christianity and anti-Blackness (p. 258).

For Black women with “bigger” bodies, we not only have to look at the mental, emotional, physical, and spiritual ramifications of these crooked rooms; we also must consider the “fat”

oppressed “identity” for Black women living in a gendered, racialized, and “fatphobic” society and the “disastrous consequences” this has for Black women with “bigger” bodies.

Black people and Black women’s bodies have strongly “aided” the success of medicine in this country (Randall, 1995; Myles, 2013; Byrd & Clayton, 2001; Axelsen, 1985). Black people and Black women’s bodies have been sacrificed as a key tool of medical practice and subjectivity (Washington, 2006). The crooked room in this project is the medical environment, the crooked room of medicine (CRoM). I understand Collin’s matrix described above as being what creates the crooked room. The Matrix explains how people are silenced, the crooked room is part of the matrix, that is a room within the matrix.

I also utilize Medical Sociology to debunk false narratives in efforts towards inclusive health practices. The National Library of Medicine (2012) states that,

Medical sociology is concerned with the relationship between social factors and health, and with the application of sociological theory and research techniques to questions related to health and the health care system. Typical areas of research include the influence of ethnicity, gender, age, or socioeconomic status on the access to and quality of health care; health and risk taking behaviors; social constructs of illness; health beliefs and perceptions; health effects of sociocultural changes; the role of health institutions and health professionals in society; the social implications of biomedical innovations, education, and communication; and other sociological aspects of medical organization and practice.

There are social patternings of health that continue to affect marginalized people (Nelson 2003).

Dissecting the Crooked Room of Medicine (CRoM)

In the crooked room of medicine and medical settings, Black women have historically suffered and been erased. Stereotypes have historically been the driving force and justification of treatment of Black women’s bodies throughout society. These stereotypes, labels, and the degradation of the Black woman’s body became prevalent during the time of enslavement in the

U.S. and has been ingrained into the structure of society. Deborah Gray White (1999) insisted that “African and African American women were not born degraded but rendered so by enslavement” (p. 8). These are all lived documentation of Patricia Hill Collins’s (2000) matrix of domination stereotypes derived from, racist, classist and sexist connotations, such as that of the “Welfare Queen” specifically. Recently, Black feminists, activists, and even Black women rappers have reclaimed these stereotypes placing a positive spin on these tropes.

With reference to Dietz (1995), because the seven-year-old Black girl’s appearance was not that of Western white aesthetics, and as a result of the misogynoir medical curriculum, his singular observation became accepted science. His credentialing and positionality in society allowed Dietz to pathologize her body as “other.” As Bailey (2016) points out, this is similar gendered and racialized rhetoric that is common among physicians, medical curriculum, and conversations, as well as social biases rhetoric in regard to Black women and their bodies, known as misogynoir rhetoric. As she mentions, this rhetoric is extremely harmful for Black women’s health and contributes to high death rates. Not only was Dietz’s career furthered by his medical observation and case study documentation of her, that documentation turned into medical behavioral health theory furthered by other privileged bodies and academics, therefore continuing racialized and gendered misconceptions about the whole Black woman population. Racialized and gendered misconceptions can be seen as negatively contributing to the health of most Black women in Western society, from stereotyped misconceptions to medically documented information.

In chapter six of her 2020 book *Hood Feminism* entitled “How to Write about Black Women,” Mikki Kendalle provides a quick parody “How to...” guide on how Black women are or have been historically and traditionally written about in society:

First, state your credentials. It's okay to be a woman, but not a Black woman...Make it clear that you are not racist or sexist, you are merely concerned about their plight. What plight? Well, pick one. Or several. Marriage, children, lack of either, too much education, not enough education, welfare, whatever you think will sell. It only matters that you highlight their troublesome natures. Whatever it is, you must be sure to make it clear that they aren't like other women. They are failing to perform in some way that affects the whole of society, even if you can't quite explain how or why their personal lives are public property. Further, rely heavily on the idea of research that shows the problem is a problem...Utilize stereotypes whenever possible, preferably ones that tie into the Mammy, Jezebel, or Sapphire tropes. Describe Black women in ways that play up their sexuality and remove their humanity. After all they are Other...If you are speaking of Black mothers, make it clear that they need guidance, financial support, or salvation...Well, that all depends on whether they work too little and thus are on welfare, or work too much and thus are neglecting their children...There is no point at which they can balance work and family, because, again, they are Other and that is not possible for them...Their voices are too loud, too uneducated, or simply too aggressive. They are always angry about something...Write of how you studied them at a safe distance...Contrast them with women of other races...All of it is true because you say it is, and you are the expert in Black women, not any actual Black women. If they are offended by your words, remind them of your credentials and refuse to engage in a conversation with them until they can be less emotional. Point to their tone as a reason to doubt the veracity of their experiences. After all, they are only Black women and thus they know nothing, own nothing, and are worth nothing but what you say they are. (pp. 86–88)

Kendall's "How to write about Black women" guide may read as sarcastic and snarky; however, there is truth to her outline, particularly when she points out that credentialing and having a credential makes one that is studying or documenting Black women more of an expert than actual Black women themselves (i.e. William Dietz and those that furthered his theory). Kendall points out that when post-slavery philosophy seeks to "uplift the race" by correcting the "bad" traits of poor and working-class Black people, this philosophy conforms to a societal expectation that centers on managing the behavior of Black people, largely Black women, and therefore continues to other Black people and Black women as needing to be fixed. By using terms such as "falling behind" and "off the charts" to describe Black women, it suggests these subjects need to "rise up" to the rest of society to reach "normalcy" or average status.

Misogynoir

In the same text, Kendall highlights misogynoir theory in regards to how Black women are written about as abnormal. She states:

In an era marked by rising inequality and declining economic mobility for Black Americans, the modern version of the politics of respectability works to accommodate misogynoir. *Misogynoir* is a term coined by queer Black feminist professor Moya Bailey to ‘describe the co-constitutive, anti-Black, and misogynistic racism directed at Black women, particularly in visual and digital culture’ (2010). The term is a combination of *misogyny*, the hatred of women, and *noir*, which means black but also carries film and media connotations. ‘Representational images contribute to negative societal perceptions about Black women, which can precipitate racist gendered violence that harms health and can even result in death.’ (2016, p. 1)

This same notion of misogynoir is also the same rhetoric that Dietz (1995) operated in his case study narrative of the young seven-year-old Black girl. Though not explicitly stated, the stereotyped ideology of “the welfare queen” (socioeconomic status) as well as Western ideas of what a feminine body should look like when deemed as “healthy,” with regard to his medical credentialing, Dietz wrote “scholarly” assumptions of this young Black girl regardless of his own test results’ indication of her health as “unremarkable.” His false and deficit rhetoric of the young girl was then furthered by other doctors and scholars, which gave access for medical authorities (like Dietz) to study and pathologize a perfectly healthy girl (and girls like her) because she did not fit into the box of Eurocentric health standards.

Dr. Moya Bailey utilizes two cultural examples to “explore the ways in which the biomedical knowledge produced by physicians reinforces certain bodies as normal and others as pathological. The case of South African runner Caster Semenya, as well as the trial of R&B star R. Kelly, allow [her] to introduce Black feminist health science studies as a critical intervention into current medical curriculum reform conversations” (p. 1) and highlighting “the importance of

aesthetics in both medicine and social logics, a correlation that is rooted in the origins of medical education” (p. 2). Bailey exemplifies how the 2009 controversy surrounding world-class runner Caster Semenya demonstrates the inimitable collaboration between “socially constructed biases and medically derived standards, which collude to pathologize some bodies more than others” (p. 2). Bailey also highlights how the prosecution team in the R. Kelly trial tried to adapt the didactic medical medium of the Tanner Scale to prove the age of the girl in the video, raising important questions about how observation becomes science and science becomes medicine that can be evaluated in a court of law (Vineyard, 2004).

Intersectionality and the Crooked Room of Medicine

Another theoretical framework that is guiding this study is the Black feminist concept of intersectionality, coined by Kimberlé Crenshaw (1989, 1991) but originating much earlier by Black feminist such as those from the Combahee River Collective (year). By asserting the interlocking effects of gender and race, intersectionality shows us the complexity of Black women’s experiences. Intersectionality explains how lived identities are experienced as interlocked with systems of oppression (Collins year). Black women experience these interlocked systems of oppression every day. The idea of intersectionality counters the notion that one fundamental type of oppression is the major source of all hierarchies. This study looks at the intersections of gender, race, and weight, particularly in the medical sphere.

I introduce the Gender Race Weight (GRW) matrix to this discussion of Black women’s health experience and the crooked room. Crooked rooms create health disparities and morph this complicated GRW matrix. Within this matrix, a multitude of circumstances exist. I argue that Black women may suffer from a higher “obesity” health disparity rate compared to other women

in the U.S. due to the impacts of systemic oppression, bias, and unequal treatment of Black women (Williams & Sternthal, 2010; Anderson & Massey, 2001; Oliver & Shapiro 2006; Chinn, Martin & Redmond 2021). Therefore, weight might be a symptom of the stress of navigating social ills for Black women. Moreover, fluctuating weight gain can be a symptom of living in a racialized gendered society rather than a genetic disposition of Black women. Of course, everyone is different, and Black women are not a monolithic group; we are diverse in both nativity and ethnicity, comprising multiple cultures, languages, and experiences (Agyemang, Bhopal & Bruijnzeels, 2005) and therefore Black women's weight should be accessed on a case-by-case basis. Within the matrix, there are also other circumstances that interlock with marginalized experiences that also affect health outcomes such as internalized oppression, self-hate, eating disorders, addictions, and so on. Again, it really becomes this matrix of scenarios because everyone is different. Furthermore, Black women's health or indications of "unhealthiness" oftentimes have nothing to do with weight and everything to do with what is going on around us and how we are navigating such circumstances. That's why when certain bodies enter medical spaces and the visit focuses on weight it can be viewed as a disservice for the patient involved.

In Dorothy Roberts's 1997 book *Killing the Black Body*, the author unmaskes the U.S.'s repeated abuse of Black women's bodies, from slavery's economic investment in Black women's fertility to government programs that strongarmed thousands of Black women receiving government assistance into being sterilized as late as the 1970s. Roberts conveys how the stereotype image of the "welfare queen" has been interlaced into white America's view of Black women. She explains how this stereotype has impacted government policies about Black women's reproductive decisions. She discloses how government plans to alleviate poverty included the requirement of birth control implants as guidelines for receiving government

assistance. Why do the government and policy makers feel they have so much authority over Black women's bodies? White men were the only ones "qualified" for these positions of power (policy makers, physicians, and government officials) during the time of slavery. Therefore, white and masculinist racialized frameworks of society have been dictating Black women's reproductivity, sexuality, and body since the era of slavery. Roberts highlights how the "welfare queen" stereotype played a key part in medical and governmental reproductive violence of Black women's bodies and their babies. Roberts's Black feminist framework centers Black women's experience with the government-entitled authority over their own reproductive organs. Her work reflects how racialized and gendered power dynamics are reinforced throughout society. Social reinforcement/ideologies render white men with social power, a sense of authority over others. In this crooked room of governmental space and policies, Roberts provides space for Black women's experience with government policing. Revealing how the government uses oppressive tactics that reinforce racial and gendered ideologies.

Khiara Bridges's 2011 book *Reproducing Race* also demonstrates how the "welfare queen" stereotype of Black women impacts medical treatment of Black women, specifically maternity care in a hospital in New York City. Bridges unfolds how the intersectionality of race, gender, and class holds powerful material consequences for these Black women, displaying how they are marginalized by the practices and assumptions of the medical staff. The entanglement of inequalities of these women puts them in the face of infant and maternal mortality. Black women die at high rates during childbirth. In New York state alone, the Department of Health found that three times more Black women died from pregnancy-related complications than white women, and this disparity persisted even when college-educated Black women were compared with non-

Black women who did not finish high school. More than 60% of these deaths are preventable if appropriate care is given in a timely fashion” (Farrington, 2020).

As recent as 2020, accounts of Black women dying during childbirth have gained national attention because of the high-profile deaths of Dr. Shalon Irving and Kira Johnson and the delayed response to Serena Williams’s request for treatment of a post-delivery complication. In July 2020, 26-year-old Sha-asia Washington died during a C-section in Brooklyn, New York, and on October 24 2020, Charmaine Wallace, M.D., died four days after her daughter was born in Indiana. Dr. Wallace’s story shocked a great number of people because not even her education nor class could save this Black woman from the crooked room of the medical setting.

Black women also have higher rates of giving birth to premature infants than other women in the U.S. In Dana Ains-Davis’s 2019 book *Reproductive Injustice*, she examines the role of medical racism in the lives of Black women who have given birth to premature and low-birth-weight infants. She focuses on professional Black women, who are just as likely to give birth to premature infants as low-income Black women. The imagery of low-income Black women being at greater risk to give birth to premature infants than middle-class or professional Black women is probably due to the “welfare queen” stereotype. What makes this book unique is that it centers women whose social location — through their attainment of higher education and professional status — complicates common presumptions about who “carries” the risk factors leading to adverse birth outcomes. It is Black women —who are professional and college educated — at the center. Importantly, they too give birth prematurely at higher rates than white women with the least amount of education. Referring to the shock of Dr. Charmaine Wallace’s death, as a society we forget that no matter how “progressive” or nonracist, or “how long ago” slavery was, racist ideologies and stereotypes from slavery continue to impact how society operates today. Slavery

and the stereotypes used to justify slavery impacted and still impact how society views and treats Black people in and throughout various institutions. The institution of medicine and medical settings was and still is a crooked room for Black women.

Davis argues that Black women's pregnancy and infant prematurity and mortality rates are expressions of what Saidiya Hartman (2007) refers to as the afterlife of slavery:

Slavery had established a measure of man and a ranking of life and worth that has yet to be undone. If slavery persists as an issue in the political life of Black America, it is not because of an antiquarian obsession with bygone days or the burden of a too long memory, but because Black lives are still imperiled and devalued by a racial calculus and a political arithmetic that were entrenched centuries ago. This is the afterlife of slavery — skewed life chances, limited access to health and education, premature death, incarceration, and impoverishment. I am the afterlife of slavery. (p. 6)

Black studies research points to the era of slavery as the start and foreshadowing of continued devaluing, inequality, and inhumane treatment of Black people in the U.S., especially pertaining to health (Randall, 1995; Gaskin, Headen & White-Means, 2004; Green & Darity, 2010; Krieger et al, 2005; Pamies & Nsiah-Kumi, 2009; Kramer et al, 2017; Hammonds & Reverby, 2019) . Slavery foreshadowed the labeling of disease, brutality, and oppression of Black Americans to contemporary events including the “health disparities” of today.

Racism, Stress, Weight

Black women may indeed have higher BMIs, but there are a multitude of reasons why. BMI is a flawed measure for health (Bryne 2020). Research shows that the most racially oppressed group in the U.S. is the Black woman, experiencing daily stressful situations linked to poor health outcomes (Essed, 1990; Collins, 1991; Clark et al., 1999; Jones, Cross, DeFour, 2007; Brown et al., 2003; Harrell, Hall & Taliaferro, 2003; Brondolo et al., 2008). Black women are at greatest risk for health disparities in the U.S. (heart disease, stroke, cancer, obesity, diabetes,

mental health disease, etc.) compared to their white counterparts (Asiedu et al., 2017). Though the gap may be narrowing, significant health disparities between Black and white Americans exist (CDC, 2016). Studies show that stress from racism is correlated with “obesity” in African American women (Cozier et al., 2009; Mwendwa et al., 2011).

Mwendwa and colleagues (2011) state that “the notion of having to cope daily with perceived racism could result in the overuse of the stress response mechanism, which may increase the risk for health-related problems such as obesity in African American women” (p. 603). Stress and its effect on bodies, especially in the form of increased weight in Black women’s bodies, is what Hicken and colleagues refer to as a “layered influence.” First, research indicates that consumption of high-calorie, high-saturated fat foods in response to psychological stress results in the release of certain biochemicals known to reduce feelings of stress (Dallman et al., 2003, 2005). Second, psychosocial stress alters metabolism to result in “visceral adipose deposition specifically” (Dallman et al., 2005). Finally, there are racial inequalities in psychosocial stress and social stressors (Jackson et al., 2010; Schulz et al., 2005; Turner, 2009). The concept of a layered influence suggests that all these processes should be considered when evaluating Black women’s body size and health. Because we live in a society that is racialized, gender biased, and “fat”-phobic there is an emphasis and fetishization with weight.

Oftentimes, “weight” is not the main issue at all.. Society puts a lot, often too much, emphasis on weight and reaching a “healthy” weight, which is part of the crooked room. Oftentimes, other issues which minoritized and marginalized communities face contribute to so-called “bad” health (stress, racism, lack of access, etc.) — entanglement of interlocking experiences of oppressions, therefore causing a list of symptoms and consequences. Weight gain is often one of many symptoms of these experiences. Programs and interventions that only

address individual choice and habits are just band-aids on larger issues in communities of color. In sum, yes, these stress-weight-racism-metabolism dynamics may indeed lead to bodies that are not as “healthy” as they could be. However, we need to address the structural issues that produce that dynamic rather than intervening at the individual level via medicine and the social level via stereotypes.

Intervening at the structural level is a concept and perspective that should be taken into serious consideration by doctors and medical student training.

I cannot tell you how many times I have cringed when doctors tell my mother to “eat right and lose weight” during her cancer checkups or pertaining to her knee complications, as if she’s not already eating right, not to mention how hard it might be to be physically active if you have a persistent knee problem. Focusing on weight when one goes to the doctor for cancer or arthritis seems like a disservice, not to mention the emotional toll it takes on a person to consistently hear, “You need to lose weight and that will solve all your problems.” My mother is a 67-year-old woman that takes care of her 78-year-old disabled brother and 63-year-old disabled sister, on top of other stressors and daily issues. Focusing on services or tools to help her navigate her outside life would seem to be more effective in keeping cancer cells in remission rather than a discussion on weight.

Black feminisms and “fatness”

Data found in the 2017 report on “The Status of Black Women in the United States” (authors) reveals that Black women continue to experience a range of health inequities, which in most cases are connected to poverty and stress. According to the National Institute of Health (NIH), over half (56.6%) of Black women in the U.S. are “overweight” or “obese”; however, it

should not be immediately assumed that these women are not healthy (Fryar, Carroll, Afful, 2021). Research also reveals how these early negative stereotypes of Black people, specifically Black women, still impact the medical treatment and health of Black women perceived as large and connect to contemporary health disparities.. When femininity is seen as correlated to “fatness” and Blackness, it is automatically negatively stereotyped and labeled as “too much,” “off the charts,” “unattractive,” “diseased,” “diabetes,” especially within medical institutions.

Black people, specifically Black women, have been labeled to be at “greatest”/ “highest” risk for health disparities in general in the U.S. for centuries. There has been a multitude of public health campaigns, grants, programs, etc. to close various health-disparate white-Black gaps across the United States (Oliver, 2005; Office of the Surgeon General (U.S.); Office of Disease Prevention and Health Promotion (U.S.); Centers for Disease Control and Prevention (U.S.); National Institutes of Health (U.S.). The Surgeon General’s Call to Action To Prevent and Decrease Overweight and Obesity; Rockville (MD): Office of the Surgeon General (U.S.), 2001). Unfortunately, most programs try to “fix” the problems at the individual level, but there are a lot of structure level fixes that need to occur. For centuries, the poor have been blamed for their social circumstances and health-disparate status in America (Moynihan Report, 1965; Lewis, 1966; Hogarth, 2017). Sociologists have even placed blame on the Black single mother for the health-disparate deprivation of the Black community (Wilson 2012). The “obesity” epidemic is the most common health disparity that Black people and Black women face. According to the CDC (2011), the “obesity” epidemic spread rapidly during the 1990s across all states, regions, and demographic groups in the United States. Obesity is defined as being over 30 percent above ideal body weight (Mitchell et al 2011). This so-called epidemic is ingrained in U.S. popular thinking, enabled by social and other forms of media, and like much U.S. popular discourse,

focuses and places blame on individuals rather than structures or systems. As I mentioned earlier, I entered the discipline of public health believing that individual-level interventions were both appropriate and helpful. Recently, during the COVID-19 pandemic, Black studies scholars have critiqued the ways in which the behavior of Black people and the poor has been used to explain the high diagnoses and deaths within these communities. In an April 2020 Department of African American Studies article entitled “Black Skin, White Masks: Racism, Vulnerability & Refuting Black Pathology,” Ruha Benjamin describes how pathologizing Black behavior in correlation with deviance and negative behaviors, especially in terms of “health,” is authentically a part of U.S. American culture. She affirms that the “culture of poverty” script is a reliable alibi that lets the bad behavior of powerful institutions (societal structures) off the hook and goes back to at least the Moynihan Report, in which Black women in particular are blamed for the so-called dysfunctions of Black families and communities. Benjamin states that “anti-Blackness distorts reality, interpersonally and institutionally, exposing Black people to a threatening environment well before the pandemic”.

In an op-ed published by the *New York Times* in July 2020, sociologist Sabrina Strings argues that it is not due to the “fatness” and “obesity” of African Americans that they are dying at higher rates of the COVID-19 virus. Strings states, “The era of slavery was when white Americans determined that black Americans needed only the bare necessities, not enough to keep them optimally safe and healthy. It set in motion black people’s diminished access to healthy foods, safe working conditions, medical treatment and a host of other social inequities that negatively impact health” (page # or paragraph). Dietz’s (1995) Food Insecurity-Obesity paradox reflects the deficit narrative of African Americans not having enough and surviving on the bare necessities when it comes to food access and “healthy” eating and living.

Strings debunks the recent explanation of African Americans' high susceptibility rate to the COVID-19 virus, which is a false narrative that suggests that due to African Americans having higher "obesity" prevalence they have high susceptibility rates to the virus:

This message is particularly important in a moment when African-Americans [*sic*] have experienced the highest rates of severe complications and death from the coronavirus and "obesity" has surfaced as an explanation. The cultural narrative that black people's weight is a harbinger of disease and death has long served as a dangerous distraction from the real sources of inequality, and it's happening again....Promoting strained associations between race, body size, and complications from this little-understood disease [COVID-19] has served to reinforce an image of black people as wholly swept up in sensuous pleasures like eating and drinking, which supposedly makes our unruly bodies repositories of preventable weight-related illnesses."

Dietz's (1995) Food Insecurity-Obesity Paradox theory reflects this belief of body size and illness.

In Strings' 2015 article "Obese Black Women as 'Social Dead Weight': Reinventing the 'Diseased Black Woman,'" Strings examines the nature of the "obesity" epidemic rhetoric and Black women. She argues that the discourse portrays the "obesity" epidemic as a Black woman problem. Strings asserts that rather than being a genuine concern about Black women's health or public health, "the medical and popular discourse about obesity and black women is largely a reproduction of the trope of the diseased black woman that has been used throughout American history" (p. 108). This trope is a stereotype that reifies the purported sensualism of Black women. Strings explains that "within this trope, African American women lack control over their sensual appetites and are thus willing to engage in deviant, high-risk behaviors" (p. 108). She further explains that Black women's sensualism is not only deemed responsible for their diminished health and well-being; it also makes them deadly agents of disease.

According to Strings, this stereotype and notion aligns with the statistics of Black women's health and high-risk behaviors dealing with HIV, cancer, heart disease, and, of course "obesity." Moreover, this discourse is distinct in that it portrays Black women as signified "social dead weight" (p. 107). Strings clarifies that this trope refers to Black women's sensualism, also known as the "Jezebel stereotype," that perpetuates a sensual appetite for deviant and "high-risk" behavior. This stereotype is used to justify the high/huge health-disparities gap, pointing blame back to the individualistic deviant behaviors of the poor and marginalized populations. Strings demonstrates how this centuries-long old stereotype of the "deviant", "risky" Black woman lacks control of even her own appetite, leaving her most vulnerable to "obesity."

Andrea Elizabeth Shaw (2017) also examines "fatness," Blackness, and the female body. Shaw states, "In the United States, fatness and blackness have come to share a remarkably similar and complex relationship with the female body: both characteristics require degrees of erasure in order to render women viable entities by Western aesthetic standards" (p. 1). Shaw holds space to show past and contemporary resistance of white "norms" of health and beauty, which does not always include "fatness" nor Blackness. She reviews the ways the African diaspora has pushed back on Western society's obsession with female slenderness and the market that promotes "fat" fear. She does this by providing literary and cultural readings of novels, poems, short stories, films, television programs, advertisements, music videos, and the public reception of several musical performers in order to demonstrate how representations of the "hyper-embodied" Black woman resist the multiple oppressions of colonialism, racism, sexism. How "unruliness," rebellion against "norms," and resistance to this notion of white "norms" equal self-definition and determination for the "fat" Black female body, anchored in literary and cultural readings of the "fat" black woman's body in the African diaspora. Shaw's work shows how there has been a

“push back” on these inferior narratives of “fatness,” Blackness as “savagery,” and the mammy stereotype.

Sonya Renee Taylor’s 2018 book *The Body is not an Apology: The Power of Radical Self-Love* really connects this idea about the world telling Black women who we are until we yell back (metaphorically or realistically, given your process) at the world with our own definition of ourselves. Taylor takes it a step further in her theory, stating that once we accept and love who we are, that encourages us to love and accept others, pushing back on these notions that systems of oppression exist and sustain from. I see now why she references the word “radical” throughout her work. This is a radical notion - not easy to embrace within a system that tells Black women they are nothing but tropes - but holds plenty of truth. While understanding that structural changes are necessary if Black women are to be free, Taylor beautifully articulates how radical self-love can also help to dismantle oppressions:

Radical self-love encourages us to embark on a personal journey of transformation with thoughtful reflection on the origins of our minds and bodies as a source of strength. In doing this, we not only learn to reject negative messages about ourselves but begin to thwart the very power structures that uphold them. Systems of oppression thrive off of our inability to make peace with bodies and differences. Radical self-love not only dismantles shame and self-loathing in us but has the power to dismantle global systems of injustice — because when we make peace with our bodies, only then do we have the capacity to truly make peace with the bodies of others (p. 7).

I’m not going to lie, this was one of the books that I read before embarking on my own journey of healing and self-love and acceptance. At first, I truly did not understand these words. Every now and then, I would nod my head in agreement to what I was reading, but now it is as if I am reading and seeing these words for the first time. When I first read this, I can honestly say I skimmed it to understand the book enough to make quick notes, but sitting here now — in this new mental space — just reading my quickly skimmed notes, Taylor’s notion makes plenty of sense.

There is a rising sense of earnestness to challenge the systems of oppression that dehumanize bodies and strip us of our shared humanity. Taylor provides a framework that transforms the learned self-hatred of our bodies and the prejudices we have about other people's bodies into a vision of compassion, equity, and justice.

Rather than feeling helpless in the face of oppression, Taylor constructs the entangled bond between radical self-love and social justice. She emphasizes that the initial phase is recognizing that we have all been indoctrinated into a system of body shame that benefits from our own self-hatred. Taylor identifies that when we ask ourselves, “Who benefits from our collective shame?” we can begin to make the distinction between the messages we are receiving about our bodies, or other bodies, and the truth. To elaborate, when we show self-love and self-care to our own bodies, this includes showing love to our skin, skin color, hair, body rolls, and curves (or lack of body rolls and curves); when we truly appreciate our bodies, how they are as is, and not what they could be (thinner, thicker, etc.), we then appreciate our uniqueness and physical being in society. We question “Why or what makes us hate our bodies in the first place?” “Who told me to think this way about myself?” Then we come to ask, “What makes me think or feel this way about other people’s bodies?” (stereotypes, bias, etc.) That’s when we realize the same love we have for ourselves is the same love that we can share with other bodies, similar or different. This book moves us beyond our self-centered perspectives, where we are easily encouraged to forget that we are whole humans having whole human experiences in our bodies alongside others.

Strings’s 2019 book *Fearing the Black Body: The Racial Origins of Fat Phobia* looks at “fatness,” Blackness and the female body, revealing how race science was historically used to tie “fatness” and Blackness together. Her research shows that anti-fat attitudes originated not from medical findings, but with Enlightenment-era belief that overfeeding and fatness were evidence of

“savagery,” racial inferiority, and justification for slavery. U.S. health disparities are the result of medicalization of Black behavior, habits, and traits. Therefore, racism oftentimes results in death for Black people. Revisiting history with the help of Strings will connect history with contemporary health rhetoric for Black women.

Chapter II

History of Medicalizing Blackness

In 1684, Francois Bernier, early traveler and first to document race, sketched out his race theory in a letter to Madame de la Sablière, with the title “A New Division of the Earth.” A three-page manifesto, it explained his rationale for developing this new model of humankind. This was the first documentation of a racial hierarchy based on women. Bernier starts with the observation of Black women of the “Hottentot” community (Stuurman, 2000; Strings, 2019).

Madame de la Sablière was a member of the Royal Society and made significant contributions to scientific philosophy herself. During this time the pioneers of science, medicine, philosophy, and education belonged to the Royal Society and Bernier’s three-page manifesto to Madame de la Sablière would be circulated and contribute to the development of these knowledges .

At first Bernier’s original observations of Black women were made to document the world’s diversity; however, these observations were also emerging during the time of the slave trade and justification of it, therefore causing extreme harm that would carry over to contemporary times for nonwhite people. Bernier’s contribution toward creating a system of human classification based on “race,” race theories, and “race science” is overlooked. Strings (2019) asserts, “Though Bernier was first to market, scholars have typically overlooked or diminished the significance of his racial theories. But Bernier’s intervention in the field of race science was consequential” (p. 67). Strings emphasizes how his work reveals the centrality of concerns about feminine aesthetics to race-making projects since the beginning.

Bernier affirms racial differences in beauty by locating Black women's attractiveness within the extant standards for white women: "aquiline nose, small mouth, coral lips, ivory teeth, large bright eyes, gentle features." (Bernier, *A New Division of Life*, p. 249). In this way, Black women were judged "good-looking" only when they approximated the neoclassical ideal of Venus (i.e. European features).

Strings (2019) references this connection to Foucault's theory of femininity and patriarchy. She highlights, "The racialized female body became legible, a form of 'text' from which racial superiority and inferiority were read" (p. 67). The body, too, became "legible" through racial discourse, as body size was increasingly linked to racial categories (Foucault, 2012). Strings notes that Foucault suggests that at any given historical moment, specific meaning will attach to certain bodies. Frequently, this meaning is produced within the halls of power — for example, within the disciplines of science, medicine, or philosophy.

During this time bodies became legible in society — rendered into categories of inferior or superior — based on physical features, specifically body size and race. This labeling and stereotyping created the belief in an innate, race-specific genetic predisposition for laziness, stupidity, as well as an uncontrolled desire to meet the demands of the flesh at the expense of enriching higher pursuits. Because this peer group (the Royal Society) was white, and white bodies read as intelligent, their documentation was believed to be true, giving them the privilege to tell the stories of people who were not privileged to tell their own. These stories/documentations were passed on as knowledge, circulated, and accepted as true.

Physicians, surgeons, chemists, and philosophers deemed Blackness as disease during the late-18th century (Driggers, 2019). Medical "treatments"/experiments to cure the "disease" of

Blackness were framed using language and ideas from the humoral theories of the 1600s, also known as the black bile theories. In the late-18th and early-19th centuries, physicians such as Benjamin Rush and Everard Home even looked for ways to “treat” and “cure” Blackness (Rush, 1799; D’elia 1969; Home, 1821). According to these humoral theories, Black skin was caused by a superabundance of black bile beneath the skin. Blackness was considered a humoral imbalance, often an imbalance or disease of the bile. Moreover, during that time, theories circulated that an overflow of black bile could cause gastrointestinal disorders and weight gain (Radden, 2002), tying Blackness, fatness, and disease tightly together. Part of their appeal was that they provided a convenient explanation for both Black skin and corpulence. With the bile theories we see the emergence of race science, the medicalization of Blackness.

Emergence of Race Science

At the forefront of the race science emergence was Julien-Joseph Virey, the French anthropologist and naturalist. Virey was a hungry reader of bile (humoral) theories. In 1837, he wrote a book entitled *Natural History of the Negro Race*, where he would make his own claims about Black skin, gluttony, and weight. But most importantly, he made race distinctions, which became fundamental to race science. Quoted in Strings (2019), Black people, Virey claimed, were “mindless, self-gratifying automatons” who were “given up to the pleasures of the table, those great eaters, intemperate epicures who seem to live only to eat, have a stupid look...always digesting, they become incapable of thinking” (Virey, 1834, p. 25). In this way, his claims made clear physical distinctions between Blacks and whites that connected intelligence to physical features. His emphasis on gluttony and eating habits, labeling Blacks “great eaters,” worked to dehumanize Black people through racialized distinctions in early scientific literature. Race science and the medicalization of Blackness was so accepted that these derogatory, untrue,

racialized characteristics of Black people ended up in the Encyclopedia — the world’s book of knowledge, the Google of the 19th century.

Virey did plenty of “desk-bound” theorizing, never seeing many of these Black people that he felt so comfortable and authoritative writing about. Virey relied heavily on other racist accounts of Black people. Early Englishmen travelers’ documentation on what were derogatorily named “Hottentot” people, a term constructed by the Dutch and Englishmen that was then generalized to all dark-skinned people in South Africa. Research suggests that it is likely that he chose the “Hottentot” based largely on the propagation of texts that had been written about them since the 16th century (Merians, 2001). One of most influential images during this time of Black femininity and “fatness” is of Saartjie Baartman, who was marketed as the “Hottentot” Venus. Baartman was an African woman who was publicly sexually violated and put on display in early-19th century Europe, as an example of the genetic differences between Africans and Europeans, specifically those relating to Black women’s “deviant sexuality” (Collins, 1990; Washington, 2006). Baartman became known for the curvature of her body and roundedness of her hips and buttock. Her name didn’t even belong to her; her marketing name was given to her as her identity.

For men like Virey, Baartman’s body epitomized the intersection of femininity, “fatness,” and Blackness. Her presence during this time was a symbol of Black femininity that helped associate the image of the Hottentot to “fat” (Strings, 2019). Unfortunately, Baartman’s body image also helped make fatness an intrinsically Black condition, and implicitly off-putting, form of feminine embodiment in the European scientific and popular imagination (String ,2012; Forth, 2012; Shaw, 2006). Saartjie Baartman is also a well-known example of the exploitation of a Black woman’s body; after her death, Baartman’s genitals were displayed in a Paris Museum until the

1970s and her remains did not return to South Africa until 2002. Even in death her body was not her own and was used for the science of race distinctions.

The fact that Virey — and predecessors like French naturalist Buffon (see below) — documented these Black women in such a derogatory way without having physically seen them with his own eyes stresses the power that the “intellectual” theories and false, inferior notions of Black people, particularly Black women, had in the emergence of what we now know as foundational science. This also reflects the power dynamics and the racial hierarchy of who was writing “knowledge” (Collins, 1990). During this time, it was becoming part of the general misinformed knowledge that “fatness” and Blackness were related. Therefore, fatness was treated as evidence of barbarism, of a nonwhite trait.

Encyclopedia

Georges-Louis Leclerc, also known as Comte de Buffon, was a French naturalist, mathematician, cosmologist, scholar of Bernier, and member of the Royal Society. *Buffon’s Natural History*, where he foundationally linked Blackness, greed, and inferiority, was widely distributed and often quoted among French intellectuals during Enlightenment (Curran, 2011). Buffon’s fictionalized documentation of Blacks in early science and medicine created justifications for enslavement. His false accounts found particular favor among radical rationalists, such as Denis Diderot, a French philosopher, art critic, and writer, who was also a close friend of Buffon and best known for serving as co-founder, chief editor, and contributor to the *Encyclopédie* (English: *Encyclopedia, or a Systematic Dictionary of the Sciences, Arts, and Crafts*). Diderot was a prominent figure during the Age of Enlightenment (Curran, 2011; Fowler, 2011). The growing presence of Blacks in the French territories, along with the political

dialogues, may have encouraged Diderot to expand on the topic of Blacks in subsequent editions of the *Encyclopedia*. To do this, he tagged his friend, Jean-Baptiste-Pierre Le Romain. Le Romain, who had lived in the Caribbean, was a self-styled expert on French colonies and sugar plantations (*Encyclopedia of Diderot and d'Alembert: Collaborative Translation Project*, “Negroes,” 1765).

Diderot and Le Romain’s *Encyclopedia* served as an important text in the new science of race. The *Encyclopedia* seems to have been one of the earliest prominent publications to make the claim that Blacks were “fond of gluttony.” According to these scientists and philosophers, dark-skinned people, gluttony, and sin went hand-in-hand. The layers of labels and stereotypes of Black people created during this time as documented in the *Encyclopedia* was used to inform medicine, science, and numerous bodies of knowledge. From Bernier, there is the characteristic of Blacks being ugly, with the exceptions of (some) Black women being attractive to him only with European physical features. Then Buffon added the characteristics of lazy, insipidness, stupidity, plump, well-fed, and greed to the labeling of Black people. These labels brought mental inferiority, bodily differences, and poor daily habits into the definition of Blackness. Diderot and Le Romain increased the negative description of Blacks, tying in gluttony, greed, stealing, and a “penchant for pleasure.” Diderot and Le Romain’s work added a layer of deviance to the depiction of Black people. Their terminology associated Blacks as a penchant for habitual deviance and gluttony to the genetic disposition of Black people. They also associated Black traits with the seven deadly sins, linking Black people with inherent deviance and bad habits, all in the name of scientific evidence. As this dissertation will demonstrate this collaborative circle of prominent Enlightenment friends and their obsession with Blackness and circulation of these

deficit narratives were and still are detrimental to the social and medical treatment of Black people.

Experimentation as Consequence of Medicalizing Blackness through Race Science History to Contemporary

Black bodies as teaching tools and Physician Career Advancement

Harriet Washington (2007) highlights this unequal America as she describes the intentionally titled *Medical Apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present*. In it, she explains how the medical exploitation and torture of experimentation done on Black bodies was the standard of medical practice. Hogarth (2019) examines how Southern hospitals normalized the use of Black bodies for teaching and training. Physicians treated Black bodies as expendable clinical and teaching tools and used them for practicing surgical experimentations and dissections (Washington, 2007; Savitt, 1982). Physicians, especially during plantation slavery in the U.S., built careers from exploitation of Black bodies, whether through theories or physical experimentation, building famous careers from oppressive tactics (Axelsen, 2012; Driggers, 2019).

Dietz's (1995) paradox theory functions in the same jurisdiction. The young seven-year-old Black girl was "used," as theory was built around her "case" for the advancement of his career. Deirdre Cooper Owens (2016) examines this practice in her book *Medical Bondage* by focusing on the career of James Marion Sims, considered by many to be the "father" of gynecology. Sims's "nurses" were enslaved Black women who not only had to tend to slave duties, including taking care of the Sims family, while also being subjected to Sims's experimentations on their genitalia, as well as function as nurses during his experimentations on

other Black enslaved women, all in the name of gynecology and advancing his career. “Black women remained flesh-and-blood contradictions, vital to their research yet dispensable once their bodies and labor were no longer required” (Owens 2016, p. 3).

Dr. Benjamin Rush’s misconception that Blacks had “thick” skin and could tolerate pain more than whites, is the same ideology that Sims operated under when he performed his surgeries on enslaved women. He stated that the “stoicism of the Negro” made it possible for him to continue his surgical experiments (1884). According to Sims, “stoicism of the negro” is a belief that Blacks had higher pain tolerance, thus he perfected the techniques for gynecological surgery on Black enslaved women (Axelsen, 1985; Bryd & Clayton, 1996; Randall, 1995). He performed surgeries repeatedly on the same women with no anesthesia, even though anesthesia was available during this time. A young slave woman, known only as Anarcha, for example, underwent some 39 surgeries over four years (Axelsen, 1985; Bryd & Clayton, 1996). Sims became interested in the condition of vesicovaginal fistula in 1845 when Anarcha developed a fistula after a prolonged first labor. Within days, two more slaves with this condition, Betsey and Lucy, were referred to Sims by their owners. It is documented that Sims’s first operation on Lucy was outstandingly agonizing for her. These women had to be forcibly held down on the table in order for Sims to operate (Washington, 2006).

Dietz’s (1995) notion operates via similar rhetoric, removing the young seven-year-old girl’s autonomy and writing a futuristic narrative of her and other young Black girls like her into a pathology of illness and a life of “obesity”-related disease, insensitive to the young girl’s feeling of otherness, more concerned with his own personal drive for “success” in creating this theory. Axelsen concludes her article by asserting that “a real societal commitment to the health of Black

women thus will require a major change in the values which underlie the entire system of the development and provision of health care in America” (p. 12).

Black women’s bodies and medical and government abuse and experimentation

This unethical and oppressive medical history has led to a disregard for Black female autonomy by physicians and government programs, contributing to a distrust between Black folks and medical professionals. Randall (1995) and Washington (2006) both document how this distrust has been perpetuated through time by revealing the evidence of the mass sterilization of Black women between 1930 and 1970 and today’s disproportionate number of hysterectomies performed on Black women. It is estimated that 100,000 to 200,000 sterilizations were performed (Davis, 1981; Washington, 2007; Rosenthal & Lobel, 2011).

By 1983, 43% of the women sterilized in government federally funded family planning programs were African American (Greer, 1984). The most troubling yet key element is the government’s funding and sponsorship of these abusive practices. Washington (2007) notes how “forced sterilization and welfare have been linked for nearly half a century” (p. 203). Harris-Perry also states that “welfare policy is intimately linked in the American imagination with Black women’s sexuality” (p. 68). Washington (2007) explains that in 1958, Mississippi state legislator David H. Glass instituted a bold experiment when he sought legal means to force sterilization upon mothers who at the time relied on government assistance. Most sterilizations of poor Black women “have been performed outside the law and in violation of medical mores” (Washington, 2007, p. 203). Sterilizations were often performed when pregnant women in labor entered a hospital. Other times, the physician removed the woman’s uterus after coercing or tricking her into an agreement for unnecessary sterilization. Women were also sterilized while unconscious, as

civil rights leader Fannie Lou Hamer was (Washington, 2006). Hamer was a famous example of a Black woman who went into a hospital in 1961 for removal of a uterine tumor, and without her knowledge or consent, doctors performed a complete hysterectomy (Washington, 2006).

“Involuntary hysterectomies were also commonly practiced in the North. The number of women of color who were sterilized over the course of the several decades when national policy and funding were heavily influenced by the Eugenics movement, which was developed from race science rhetoric. To accomplish the sterilizations, practitioners lied to patients, forged consent forms, or falsified medical records to reflect an ‘appendectomy’ or ‘gallbladder removal,’ so it is now impossible to know the exact number of African American women who were sterilized without their knowledge” (p. 204).

In a 2020 study, “Discrepancies between racial/ethnic groups and choice of hysterectomy procedures”, researchers reported that:

Although being eligible for minimally invasive hysterectomy, women of African American and ethnic minorities were more likely to receive abdominal hysterectomy compared to whites. The percentages of all women undergoing abdominal hysterectomy were highest at hospitals serving mainly African American populations. This may also lead to disparities in outcomes, in part owing to the higher complications in open surgeries and suggest that minority women might experience lower access to minimally invasive surgery” (Pollack, Olsen, Gehlert, Chang & Lowder 2020).

Contemporarily, a disproportionate number of hysterectomies are done on Black women.

Where Crooked Rooms Collide (Welfare Queen Image and Medicine)

Scholars show that reproductive oppression and abuse of Black women’s bodies has been achieved under the sponsorship of a government fed by the myth of the lazy, hyper-fertile welfare mother. When the term “welfare mother” is mentioned most people think of an unemployed Black woman, yet most women who depend on the government for assistance at some point in their lifetime are not Black (Washington, 2006). Melissa Harris-Perry (2011) discusses the “welfare queen” image and its effect on past and contemporary treatment of Black women. She explains that the webbed myth of the single, hypersexualized Black woman with many offspring taking

advantage of government funds ultimately punishes Black women based on false assumptions. Harris-Perry's work tells the story of how negative stereotypes affect individual Black women as political actors and impact all realms of their lives/lived experiences, creating a crooked room of lived experiences.

Dorothy Roberts's 2007 book *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* also examines how the "welfare queen" stereotype shapes government policies concerning Black women's reproductive rights. She notes that "eugenicists opposed social programs designed to improve the living conditions of the poor. They argued that adequate medical care, better working conditions, and minimum wages all harmed society because those measures enabled people with inferior heredity to live longer and produce more children" (p. 65). Roberts (2011) further explains the "explosion of rhetoric and policies that degrade Black women's reproductive decisions" (p. 4) by focusing on the ways in which poor Black mothers are blamed for perpetuating social problems by transmitting defective genes. This notion was highlighted, in the aforementioned discussion of Black pathology and the 1965 Daniel Moynihan Report, also known as "The Negro Family: The Case for National Action." This report blamed single Black mothers for the social and "genetic" ills of Black people. This thinking was supported by the bestselling book *The Bell Curve*, which claims that social disparities stem from the higher fertility rates of genetically less intelligent groups, including Blacks. Moynihan represented New York in the Senate as a Senator from 1977 to 2001. He was also another white male "influencer" who built his career on degrading Black people through reports, literature, and later policy operating under and furthering the rhetoric of otherness, pathology, and gendered racialization in reference to Black women.

Roberts explains how in the 1990s the,

“state legislatures across the country were considering measures designed to keep women on welfare from having babies...The plans range from denying benefits to children born to welfare mothers to mandatory insertion of Norplant as a condition of receiving aid. Many family-planning clinics, with the support of Medicaid, are already encouraging young Black women to keep the risky device implanted in their arms” (p. 5).

This highlights how involved the government has been in Black procreation and how the influence of racialized, gendered rhetoric and otherness has been associated with to Black women and motherhood.

The notion that most single Black women with children are on welfare or some type of government assistance is a false-deficit narrative. You see this to be true with William Dietz’s food insecurity-“obesity” paradox. This notion implies the stereotype that Black female-headed households have federal assistance experience; the unstable, unhealthy food cycle — because they are unable to take care of themselves — leads to an “obesity” diseased lifestyle path and habits. This proves problematic because it perpetuates a pathology of deviance and Black people being unable to appropriately take care of themselves via “healthy” habits and leaning on government dependence. It also perpetuates the idea that single Black mothers cannot properly care for their children with healthy food options, predicting that this can lead them to an “obese” lifestyle. The aforementioned concepts of the “welfare queen,” government policies, and Black reproduction made way for Dietz and prospectors like him to function under a rhetoric and rewrite false rhetoric/deficit narratives that, once again, blame poor Black single mothers for health disparities in the Black community, in this case specifically “obesity.”

This stereotype of the Black “welfare queen” is false and extremely harmful (as we see). I say this from experience. As Washington mentioned, most Black women are employed full or part time and do not qualify for most to all federal assistance. As I mentioned, growing up, I was raised by a single mother who worked, and therefore we did not receive government assistance.

Currently, I am a single mother, full-time student, working part time, and I do not qualify for nor receive SNAP benefits, welfare, or other federal programs.

Physicians and government programs clearly have extreme disregard for the Black female body, reproductivity, and autonomy. Knowledge of this gritty history of mistreatment may consciously or unconsciously affect how Black American women feel when interacting with healthcare professionals. It may also contribute to the anxiety they feel throughout their lives about having children, particularly during pregnancy when these issues are especially relevant.

Just like the feelings, experiences, and apprehensions of my mom's trust with medical professionals in her recent health journey, or my recent fear and nervousness of myself or my daughter dying during her birth in 2019. With the recent information and numbers about Black women and complications during childbirth, I was a nervous wreck. Beyoncé and Serena Williams had just given birth and were extremely real and transparent about their negative experiences. If their fame and money could not stop them from the ill treatment of the medical field in this day in age, where did that leave me, a single working student? Especially considering my locality in Southwest Virginia, where I only lived because of my PhD program. An expectant mother should be full of joy and excitement to deliver her baby, not fear death because of her race.

Black Women and BMI

In the 2002 third National Health and Nutrition Examination Survey (NHANES III) report, Katherine Flegal and colleagues at the CDC noted a steep rise in “obesity” among Black women. This report was one of the earliest and most highly visible studies of obesity by race and gender since the obesity epidemic had been announced in the 1990s (Centers for Disease Control

and Prevention, 1999). Since and before the 2000s, Black women have been categorized to have among the “highest” BMIs in the country; their size was also evidence of disease (Strings, 2019; Gordon, 2020). The 2000s “obesity epidemic” and the propaganda around it continued to push the now 300+-year-old narrative of large Black women unable to control their animalistic appetites, single mothers living in poverty, unable to control their health, unknowledgeable of “healthy” eating habits, dependent on food assistance, and putting their children at risk of this morbid “fat” disease — with the childhood “obesity” epidemic ensnaring every media platform as well. “Yet again, black women were to become the focus of fear, anxiety, and degradation over the size of their bodies” (Strings, 2019, p. 203).

The stereotyping of Black women’s bodies as overfed is aided by instruments like the Body Mass Index (BMI) which, according to food and health journalist Christine Byrne (2020), is “[sexist], racist, and useless.” Byrne cites Strings (2019), who, as previously noted, has outlined the history of body standards and the ways in which thinness was used to uphold white superiority as recently as the early-20th century and still a contemporary issue (Jackson-Lowman, 2013; Strings, 2019).

Created by Belgian mathematician Adolphe Quetelet in 1832 as the “Quetelet Index,” the scale was created using data from predominantly European men to measure weight in different populations. Although Quetelet noted that it was a population-level tool and not meant to be used on individuals, physiologist Ancel Keys reintroduced the calculation in 1972 as the Body Mass Index, and it has since been adopted by the medical community as a way to measure individual health. A BMI outside the “normal” range (18.5-25) is considered less healthy and an indicator of greater health risks. The problem, according to Strings, is not only that a population tool has been used to evaluate individual health, but that the tool’s development was limited to white men’s

bodies. “It is racist, and also sexist,” she argues, “to use mostly white men within your study population and then try to extrapolate that and create norms and expectations for women and people of color,” (Byrne, 2020).

In the 2019 study “That Chart Ain’t for Us: An Examination of Black Women’s Understandings of BMI, Health, and Physical Activity,” Thompson (2019) states, “While the BMI is a simple ratio, it is also a numerical classification system that has the potential to align individuals with negative attributes that are associated with ‘obese’ bodies through dominant obesity discourse...numerical classification systems ascribe social characteristics to categories” (p. 5). Research shows that the characteristics that define bodies within numerical classification systems are often a product of dominant societal beliefs and ideals (Gould, 1996; Hatch, 2016; O’Neal, 2016). Thompson (2019) goes on to state that “classification systems reinforce dominant societal ideals about race and justify racist policies and practices that can operate under the guise of science and objectivity” (p. 5). What I am suggesting is that the BMI is based on the rhetoric of the “ideal” white (and male) body standard and how that affects nonwhite bodies. I am also not claiming BMI should be gotten rid of altogether, but rather how society is currently using the tool to compare bodies, specifically to close the Black-white “obesity” gap, needs to be reconsidered. The BMI gap is not going to close because BMI is not an appropriate measure of health.

The BMI, then, is a tool that helps to perpetuate social and medical standards that privilege white bodies in comparison to Black bodies, especially when it comes to weight. Rather than dispensing with the BMI altogether, some researchers have complicated the data it appears to provide. In 2004, scholars such as Paul Campos, author of *The Obesity Myth: Why America’s Obsession with Weight Is Hazardous to Your Health*, showed that while Black women had higher BMIs than white women, they also had lower mortality rates at a given BMI (pp. 202–3). Campos

(2004) argues that Black women's bodies are pathologized into "unhealthiness" regardless of indicators of "healthiness." Revisiting the case study of William Dietz and the young seven-year-old Black girl, Dietz found her appearance to be more indicative of her health regardless of his own data results. Given two seemingly contradictory realities — i.e., high BMI but lower mortality, "overweight" but "unremarkable" health indications — MDs will default to pathologizing when it comes to Black women/patients. Power dynamics and racialized rhetoric that carried over into contemporary social standards and enable Black bodies to be pathologized. Medical institutions oftentimes create crooked rooms for Black women's bodies.

A Black Feminist's Critique of Fat Studies

When "fat" studies scholars' theorize that "fat" bodies in the 19th century were constructed as healthy and beautiful,, they aren't referring to Black women's bodies of the time because Black women were considered property (Spillers, 1994; Collins, 2002; Harris-Perry, 2011). When Naomi Wolf writes in 1991 about the ways in which beauty had evolved over time to become synonymous with thinness and a marker for acceptance after the second wave of (mainstream) feminism, which saw white women enter the work force in droves, she were not referring to Black women, who were always located in the public sphere and working (Davis, 2011; Collins, 2002; Harris-Perry, 2011). In addition, some Black cultures actually never shifted their views on Black bigger bodies because in some cultures bigger bodies are celebrated (Shaw, 2006). There is a glaring omission in "Fat" studies to discuss historical and contemporary stigma associated with fat Black women as well as cultures which continue to celebrate these women's bodies. .

The ill fit between Black feminism, "Fat" Studies and Body Positivity

Joy Arlene Cox's 2020 book *Fat Girls in Black Bodies: Creating Communities of Our Own* emphasizes why having space as well as carving out spaces for ourselves is important and necessary. She asserts that the spaces carved out by third-wave feminism and the "fat" liberation movement fail at true inclusivity and intersectionality, which strongly suggests that "fat" Black women need to create their own safe spaces and community. That is, "To be a womxn living in a body at the intersection of fat and Black is to be on the margins" (p. xvii). She interviews "fat" Black women, doing work to hold and create a safe space for "fat" Black cis, queer, trans, femme, identities (this is why throughout her work "womxn" is spelled as such). Cox (2020) exposes the racist roots of diet culture, healthism, and the ways society mistakenly conflates body size with ill-disposed personal malice. She explores how to reclaim space and create belonging in a society. She highlights Black womxn who push back on racialized gender rhetoric and dismantles the institutionally ingrained myths about race, size, gender, and worth that deny "fat" Black womxn their selfhood. Her work combats fatphobia and racism, by highlighting other Black women's work that reclaims spaces for them at the intersection of "fat" and Black.

Creating space for "fat" Black women and the process of healing from the systems of entangled trauma go hand-in-hand; that is also why these unique spaces are important. The section in Cox's text (2020) titled "What's the Power of Doing This Work while Black and Fat?" focuses on "fat" Black womxn who have created spaces such as podcasts, life coaching, magazines, and "Fat" Mermaid "IDGAF About Your Diet Susan" designs all tailored to "fat" Black woman experiences. Cox also refers to these spaces working along the lines of family, community, and portals of healing for generations to come. In Cox (2020), Ivy Felicia, The Body Relationship Coach™, spoke about the uniqueness of her lived experience as a Black "fat"

woman and the need to bring these experiences to an online platform so that other women might find healing:

In [sic] the end of 2016, I started getting a lot of revelation and understanding around being a fat Black woman and how that whole trifecta is very complex and it's unlike any other. Because you are discriminated against for being a true minority. You're Black. You're a woman. And you're fat. So, we definitely experience discrimination and challenges in a different way...I just wanted to create a space online where other women of color who are fat could heal. (p. 103)

Healing from oppression is the key to living a full and healthy life. Cox concludes this section by sharing her own process of healing through safe space and family.

So much seeking and questioning had brought me to a place of knowing. I had found my family. We had all been searching to find that place of comfort, by possibly never realizing that by searching and doing the work, we had also been creating these safe spaces within ourselves all along. We had been building homes for ourselves and for others to find refuge in. This was the knowing. I realized that in locating my family, I actually located myself. In bringing life to others, I was actually saving my own (p. 105).

Cox ends her book with a discussion of where we are as a society as far as representation, but she also pushes the idea of structural change and the importance of having both. Cox notes, "Representation is great...it doesn't equate to structural change. Seeing someone on a billboard has a whole lot less impact if that person is underpaid and unable to afford basic needs. And I'm not saying that we have to choose one over the other. We need BOTH to fully thrive" (p. 122). This emphasizes the underlying point that structural change includes both having marginalized bodies in appropriate spaces are necessary, but seeing and using them as a knowledge bases is even more powerful.

In a 2018 blog post titled "White Supremacy, Colonialism and Fatphobia are inherently tied to each other" on the website *Wear Your Voice*, guest writer Hess Love notes that even the "Body Positivity Movement" is centered in whiteness, ignoring "fat" Black bodies and women.

Love states that “the ‘Body Positivity Movement’ recently led Rebel Wilson to tell an [sic] ghastly lie about being the first ‘fat’ woman to star in a romantic comedy and then block every Black person who tried to tell her the truth, that plus-sized Black women have starred in romantic comedies before” (Women like Queen Latifah and Mo’Nique.) Love/the website?? provides the Twitter thread featuring Wilson’s comments. Reading this was confusing because the first “fat” woman starring in a romantic comedy that came to my mind was actress Mo’nique in *The Parkers*, a 2000 hit TV show that a lot of women of color had issues with as it dealt with “fat” Black women just being regarded as funny and not desired love interests. Love continues:

Fat White Women like Rebel Wilson don’t see Fat Black Women as forces of body positivity or plus-size representation because they view Blackness in itself as “large.” Blackness is already big, vast, and something they want to confine, so they make it both a boogie man and an invisibility cloak. They see Blackness as being beastlike, so to be large and Black isn’t defying expectations. In an odd way, it makes our fatness nonconsequential to them, because for them, their bodies defy the dainty expectations of a white, Western femininity. To them, that is braver than being fat and Black. Welcome to the politics of ‘taking up space.’

Love made a great point in her critique of society and movements centering whiteness while still leaving out Black women. Especially in the Body Positive Movement, Black women are unseen and unheard (Ritchie, 2017), while simultaneously hyper-visible and pathologized. This example emphasizes the crooked, unbalanced lived experience that Black women face, even within feminist movements.

Cooper Owens’s 2017 book *Medical Bondage: Race, Gender, and the Origins of American Gynecology* analyzes the complex lived experiences of enslaved Black women who acted as both nurse and experimental subject within the emerging medical field of obstetrics and gynecology. — functioning, in other words, under multiple dimensions of crookedness (as property, guinea pigs/experimental tools, nurses, medical assistants, among others). Being

dehumanized while taking on the responsibilities of personhood to care for children, being intelligent enough to assist in medical experiments, but inferior enough to be subjugated by the monster of slavery all at the same time. Leaving these women unseen, unheard, and yet simultaneously hyper-visualized. That is a lot to bear. The crookedness of the crooked room is a lot to bear. It is stressful. It is heavy. It can make you angry and enraged. It hurts emotionally, physically, mentally. It is painful. Therefore, space and a process to heal this pain is the true health goal.

Black women are still having to fight for visibility in these modern-day movements and spaces that push us to create counter-spaces specifically by us and for us (sounds familiar). Love made an insightful point, the exact point I have been drawing upon: Blackness and “fatness” are seen together because of colonialism’s early pairing of the two and the stereotypes that sustained and followed Black women to contemporary times, spilling into every aspect of life that exists for us. Until Blackness and the negative connotations of “fatness” are seen separately, continued stereotypes, ideologies, beliefs, and prejudices will impact our very existence unless we choose to not let them (purposefully working on internalized healing and self-love) or this structure changes. In the meantime, we need purposefully drawn-out spaces to safely exist and express ourselves for our own sustainment. That is the importance of this project.

The Impact

There is harm done to those who experience these interlocking oppressions — a tangled web of stickiness, abusive history, abuse by government, abuse by medical institutions, abuse by colonialism, abuse by words, abuse by society; all of these together combine to make up what is known as the crooked room. Oppression has a great impact on those who are lacking privilege

and the more that oppressive systems interlock, the greater the harm that a person is likely to experience. Oppression does a lot of damage to those of us constructed as being at the bottom of this race, class, gender hierarchy in the West. You have to find your way out to see the light; some never do. Some do not know how to process their pain, so they are either lost in the sticky web/cycle of criminalization, or they abuse their own bodies, or they just give up. Others find ways to process that hurt, anger, self-hate, and fear. Some people have documented their's and others' pain and the process of how they deal with it; others have documented pain of people who have tried to cope with drugs, sex, and abuse, which can often lead to generational pain (Dash, 2015). Healing, cultural healing, and the “process” of healing from suffering are topics that emerge in the literature for those on the receiving end of oppression and racism. Racism and oppression hurt, and there is great impact and anger that arises from them. There is harm done at all levels of the crooked room, starting when doctors point at your weight as the most important issue and sentence your body to disease and illness because of it.

Another impact of crooked rooms is internalized racism. People who are marginalized often internalize their experiences, which ignites a war within themselves, leading to self-hate. Bailey, Williams, and FAVOR (2014) define internalized racism as self-defeating cognitions that develop as marginalized people consistently experience oppression on the basis of their race. A 2019 study that examines the harmful effects of gendered racist stereotypes and African American women states, “One of the dangers of the harmful stereotypes...is the phenomenon of internalization. Internalization occurs when an individual of a minority group psychologically ingests negative messages about their own social group in a manner that damages their sense of identity and self-worth” (Mariolle, 2019, p. 4).

Crooked rooms can impact Black women in various ways, and literature often reflects a healing process from such pain, anger, and hurt. Audre Lorde unpacks the effects of racism on the Black woman's psyche in her 1981 article titled "The Uses of Anger": Women responding to racism means women responding to anger, the anger of exclusion, of unquestioned privilege, of racial distortions, of silence, ill-use, stereotyping, defensiveness, misnaming, betrayal and coopting...My anger is a response to racist attitudes, to the actions and presumptions that arise out of those attitudes. (p. 278)

With reason, anger and rage arise out of experiencing racist behavior, difficult emotions rise from oppression and injustices. As Kristina Gupta quoted, "as Susie Orbach (1997) so famously stated, "Contemporary sexist and Eurocentric appearance norms that equate feminine beauty with extreme thinness have caused women untold pain and suffering" (p. 87). Lorde examines the pain and anger of women dealing with racism, and Orbach observes the pain of women dealing with body image and expectations of thinness; both observe the impact of these two oppressions.

This next section of literature deals with the impact of the interlocking oppressions that Black women have to deal with and ultimately heal from. Many of us silently battle with internalized oppression, self-hate, and eating disorders.

I read most of all of what follows before I started my own journey of healing. All of it was just words that made sense to me logically and based on my lived experience. But now that I have started my own journey to love and self-healing, a lot of these words impact me differently and make even more sense as I place all the literature in conversation and reread my own notes. I am even eager to reread some texts now with my renewed healing mind.

Becky Thompson's 1995 book *Hunger so Wide and so Deep: A Multiracial View of Women's Eating Problems* takes an intersectional approach to the topic of eating disorders. Thompson documents how societies' "fat"-phobic rhetoric, racialized hierarchy, stress of poverty and racism, racialized experiences, and oppressions affect women. Thompson argues that marginalized (race, gender, class) women oftentimes find ways to cope via eating disorders. She writes that although eating disorders are often framed as issues of mostly teenage white women, due to the pressures to be and stay thin, living in a society such as this pushes all women to find healing from oppression and societal ills they experience within themselves.

Talking with [marginalized women] reveals that the origins of eating problems have little or nothing to do with vanity or obsession with appearance. In fact, eating problems begin as survival strategies — as sensible acts of self-preservation — in response to myriad injustices including racism, sexism, homophobia, classism, the stress of acculturation, and emotional, physical, and sexual abuse (p. 1-2).

Thompson (1995) gives us a multi lens perspective, specifically challenging what people think they know about eating disorders like anorexia and bulimia. Her work challenges the social image of eating disorders and posits that they are a combination of survival strategies, a symptom of the crooked room, and a response to the crooked room, particularly when you are looking at Black women. She further explains that the women that she interviewed demonstrate how "eating problems" often begin as an "orderly response to insane circumstances" (p. 2) Given the aforementioned history and crooked room/tangled web of reality that Black women experience, their intersecting realities in this society exemplifies combinations of insane circumstances and experiences. Therefore, responses such as eating disorders, drug abuse, physiological stress-induced responses such as mental health issues, chronic diseases, and even excess weight gain are all orderly responses to "insane circumstances."

Some of the experiences Thompson's interviewees described are of outrageous, deliberate, and sometimes brutal acts that compromised their ability to feel safe — to be comfortable and secure — in their bodies and in the world (p. 2). The crooked room deprives people of security and is therefore exhausting; it leads one to feel unsafe and insecure in their body and therefore in the world. What Thompson found was that eating disorders function as a vehicle to alleviate feelings that crooked rooms create, giving some a sense of control when other parts of their worlds feel like they had no control or “say so” in given circumstances. The words “eating disorders” can be interchanged with “drug abuse,” “binge eating,” or any other abuse or disordered illness that marginalized people battle with. Thompson argues that “bingeing, purging, and starving will continue until women's access to racial, social, sexual, and political justice is ensured” (p. 3) and the crooked room is no more. That war and pressure on the outside to reach “normalcy” turns into a war on the inside, and a continued battle within until it's healed. Thompson identifies effective methods of healing, although she recognizes that until society changes, these symptoms of oppressions will continue.

When I began this project, I did not expect the concept of healing to reach this literature. I thought they were separate. Even as I stumbled upon my own healing journey, I still did not expect to ever write academically about the concept of healing. I thought they were separate. Now that I am in the midst of both my project and my healing journey, I clearly see that these concepts of race and healing are very far from separate, given society's crooked rooms. Then I came to realize that in efforts to heal, the marginalized must seek “nontraditional” therapy due to nontraditional circumstances. Thompson (1994) explains the holistic healing process:

A holistic healing process — involving the mind, body, and spirit — draws on innovative and creative strategies. The healing methods developed by the women I interviewed reflect tenacity and a willingness to recreate what was injured or destroyed by trauma.

Healing mirrored — was the reverse of — the trauma, a discovery of aspects of themselves long lost or hidden from view. Only a few sought medical or therapeutic help; many of their strategies are not considered in medical and psychological scholarship on eating problems. Their insights have important implications for future treatment and prevention (*Hunger so wide and so Deep*, p. 107).

The concept of healing from racial trauma, poverty, and other injustices will not be included in medical or most mainstream psychological treatment of therapeutic help because “mainstream” societies don’t have to heal from marginalized problems. Therefore, they cannot relate or properly treat these ills. As previously mentioned, weight or excess weight for marginalized women could often be a reaction to injustices. Those who face those injustices daily are oftentimes Black women. There will continue to be health disparities and high rates of Black illness, disease, and death until concepts outside of Western science and nontraditional medicine are intentionally taught, diagnosed, and utilized. Traditional medicine, health departments, and scientists can’t figure out why Black people have high rates of illness, disease, and death because they are not putting or allowing the right people — Black people — in places to appropriately attack these issues. Microaggressions, various racialized and class oppressions exist within society to keep such people out of these spaces. Oftentimes if Black people are included in such spaces, crooked rooms make it difficult for them to speak their truth in fear of losing their jobs, careers, or falling into a stereotype (Khoury, 2020).

In one example, a Black doctor, Aysha Khoury, a 42-year-old internist, was recently suspended from her job at a medical school in California after she shared personal and historical incidents of racism during a talk with students. She was hired in July 2019 by Kaiser Permanente School of Medicine in Pasadena and was enthused about the school’s focus on “achieving equity,” the “elimination of health disparities,” and the promotion of “inclusiveness and diversity,” she said. Khoury was asked to facilitate a discussion about “legacies of power

structures and institutionalized racism that result in gender bias and race bias in medicine today” for an August 2020 class. She has said that she “decided to show up fully as a Black woman and physician,” wearing “a T-shirt with the words ‘I can’t breathe,’ along with my usual African print attire.” She told the class that “the lives of Black people cannot be separated from what happens within the halls of medicine,” and she asked the class to reflect on the many Black people shot by police, as well as “the long history of medical harms and abuses of Black and indigenous people, and research conducted on slaves” (Khoury 2020). She also discussed the pregnancy-related deaths of “women who look like me.” She cited research showing that pregnancy-related mortality in Black women over 30 was four to five times as high as in white women (CDC, 2019), and that Black newborns were three times as likely to die if their doctor was white rather than Black (Mahase 2020). Khoury recalls that the session was emotional and at times uncomfortable, but that discomfort was a small price to pay “if eliminating health disparities and saving lives is the goal.” After the class, the school’s senior associate dean called Khoury to tell her that she was suspended from her teaching responsibilities. “The removal from [her] faculty duties was prompted by a complaint about certain classroom activities that took place on Friday morning, August 28” (Khoury 2020). Institutional practices such as this are not new. This example highlights not only the oppressions that Black people face in career settings, but the ways in which intersecting identities shape one's experiences and knowledge , which allowed Khoury to speak and teach from these intersections and from a medical standing to new doctors. This example also highlights the power systems that stop these very important and more impactful perceptions of health and teaches more effective ways of closing health-disparity gaps (Khoury, 2020).

This example may shock some, but in my household, my mother was often fired from jobs for speaking up about an injustice or coming off too “strong” or “assertive” when dealing with supervisors, colleagues, HR, and corporate America. My mother was a payroll administrator. She prided herself in her ability with numbers; she had amazing corporate jobs including with DOLE food company, Kinko’s, Carl’s Jr/Hardees franchises, and California Federal Bank, where she dealt with large employment pay scales, policies, and procedures. But it was also easy for her to see racial pay injustices in various jobs and franchises. She was oftentimes the only Black woman in these offices and positions, making it even more difficult to call out these injustices or silently deal any other microaggressions she encountered in those corporate offices. I could see it taking a toll on her. I watched her battle with depression as she circulated in and out of employment and stability. The process hurt my soul as much as it did hers. Anxiety, depression, and anger oftentimes pervaded and suffocated my home due to these oppressions.

As previously stated, Black women have knowledge borne from their unique experiences, knowledge given validity by doctors and professionals of similar race and/or ethnic backgrounds who can relate to these patients. However, this is a moot point until institutions stop the practice of dehumanizing Black bodies and recognize those who inhabit them as knowledge bases, as human.

Racial concordance literature affirms that Black health is better when Black patients are cared for by Black doctors (Shen et al., 2018; Mahase, 2020; Greenwood et al., 2020). Because our experiences are not of the white majority, we have to look for “nontraditional” treatment, outside the medical field, or combination of both. When speaking of “nontraditional” treatments, I am speaking of things like alternative medicines, holistic treatments, herbal remedies, religious practices, and spiritual/cultural traditions and practices that are not included in Western medicine.

Kendall (2020) states that “the traumas of the past are woven into the fabric of our coping mechanisms” (p. 98). She suggests middle-class Black women in particular “...because oftentimes we have the access and resources... We have to create new [coping strategies] that don’t rely on perfectly packaged responses or ways to change ourselves to be accepted. I know we can come to a place where we embrace differences instead of pretending that freedom comes from erasing” (p. 98). Kendall is suggesting that we as Black people need to embrace who we are instead of trying to conform to whiteness, because we will be hurting ourselves in the long run. We can learn from other Black women in doing so because Black women “create knowledge,” as in create narratives that act as verifiable fact, some of which is specific to our intersectional experiences and locations, and not all of it is “credentialed.” This concept of coping strategies and intersectional teaching is not going to be taught in a traditional classroom or medical book because Black bodies were studied and not included as equal, but rather othered to be observed and have conclusions drawn about us.

...women who face injustice have much to teach about faith and resistance, trauma and coping, creativity and despair. My hope is that the book does justice to the experiences of the women I interviewed, reinforcing their ability to — in the words of Richard Wright — “create a sense of the hunger for life that gnaws in us all, to keep alive in our hearts a sense of the inexpressibly human.” (Thompson, *Hunger so wide so Deep*, p. 2)

Stephanie Covington Armstrong’s 2009 book *Not All Black Girls Know How to Eat* tells her story of poverty, self-perception, and coping, as well as her relationship with food and eating disorders. Armstrong’s book emphasizes that Black women’s experiences are knowledge that can be learned from and taught for the navigation of various crooked rooms of other marginalized women. As Armstrong tells her story, you can see how during her experiences of trauma and hardship throughout her life, her relationship with food became perplexing too. Armstrong’s insightful and moving narrative traces the background and factors that caused her bulimia all the

way back to childhood. She tries to escape her self-hatred and obsession by never slowing down and moving across the country, away from her impoverished childhood memories; she is unaware that she is caught in a downward spiral emotionally, spiritually, and physically. She comes to a point where she can no longer deny that she needs to get help, overcome her shame, and conquer her addiction to food. She also highlights how her sisters also developed addictions as a result of trauma they experienced in their childhood: one was addicted to crack cocaine, the other abusive relationships. Unfortunately, seeking help only reinforced her negative self-image, and she discovered her race makes her an oddity in the all-white programs for eating disorders. Armstrong's memoir of her experiences answers many questions about why Black women often do not seek traditional therapy for emotional problems. Most importantly, her memoir teaches Black women facing similar circumstances how to heal through a process that must be unique to them and their own needs. Oftentimes, Black women must pull from various sources to do so; this can often be draining but is seen to be worth it in the end.

I believe Stephanie and I had the same “ah-ha” moment/epiphany, linking our race to our battle with food/“eating disorder.” For me it wasn’t about the food or even the weight, more so it was my race and how I felt about my own Blackness. I think Armstrong’s story also emphasizes how and why there needs to be purposeful drawn-out space for these overlapping oppressive intersectional identities and experiences. If there isn’t space for us, we must make our own space. This is the rationale for my project, to make space for Black women to tell their own stories and experiences trying to navigate this and various crooked rooms. It was like I was trying to fill an empty hole that I would feel guilty about filling up, so I would purge it out that later during the start of my healing journey that I recognized that food, body image, someone else — no one could fill this deep, dark hatred hole but me and my journey inward.

Collins (1990) argues that an important feature of Black Feminist Thought is its insistence that “both the changed consciousness of individuals and the social transformation of political and economic institutions constitute essential ingredients for social change. New knowledge is important for both dimensions of change” (p. 553). Western society is not going to experience real change, such as the closing of health-disparity gaps, until Black people are included in appropriate spaces to do so without having our thoughts, feelings, experiences, knowledge, and actual bodies pushed out of such spaces or having our bodies extracted for other’s gains.

Multi-sided Debate

In her 2020 book *Medical Entanglements: Rethinking Feminist Debates about Healthcare*, Kristina Gupta uses feminist, queer, and crip theory to move beyond “for or against” approaches to medical intervention. Specifically, she argues that, “because of systemic inequality, most mainstream medical interventions will simultaneously reinforce social inequality and alleviate some individual suffering (but not all), as demonstrated via Armstrong (2009). Gupta provides both sides of the “obesity” argument — such that both positions are, in fact, true (and false)” (p. xi). As mentioned previously, for interventions that utilize Dietz’s (1995) paradox theory and other racialized, biased theories for behavioral health interventions, it can be agreed that weight can (in some circumstances) be seen as unhealthy — but then again, it is a symptom of larger issues that need to be addressed, rather than the be all, and end all for the marker of “health.” She claims

Part of my argument...is that critical public health approaches to weight do complicate some feminist/fat-positive positions on weight (and vice versa) and that combining the best of feminist/fat-positive perspectives on weight with the best of critical public health perspectives on weight leads to a more nuanced but still critical position on weight-loss interventions like bariatric surgery (pp. 87–88)

Gupta's notion and the previously mentioned Black Feminist Health Science Studies (BFHSS) have similar perspectives. While big calls in alleviating "obesity" and childhood "obesity" programs like former First Lady Michelle Obama's Let's Move and others are not going to close the gap in health disparities, Gupta's work shows us why. We need to interrogate such programs. Programs like "Let's Move" don't take the whole picture into consideration. Overall, Gupta is arguing that these programs are built within the system of the entangled web of interlocking oppressions, and the combination of mainstream (or white) feminist/"fat"-positive positions and public health interventions working together gives more opportunity to people to decide for themselves how to best define their own health. Health looks and is different for different people's bodies because we all are diverse, even if we fall under the same "race" category. Therefore, one should have the autonomy to decide what feels and looks good to them and their own bodies and not what a number from a BMI calculation indicates. One should have the autonomy and support to live a healthy life their own way, the way they define it outside of racialized and gendered historic rhetoric.

The issue with Dietz's (1995) paradox is that it is a false, misinformed theory based on presumptions and stereotypes that were supposed to alleviate "obesity" in predominantly Black "female-headed" households. This theory treats Black "female-headed" households as if they are all the same. His theory was furthered and revamped by other scholars in behavioral health science (Coleman-Jensen et al., 2016; Franklin, 2012; McIntyre, 2003; Dinour, 2007; Wilde, 2000; Kaiser, 2004). Similarly, Bernier's and Buffon's false, completely misinformed humoral theories were furthered by others.

When I first began my graduate studies, I worked for grant recipients that were part of the Let's Move initiative; we did community-based work in a rural predominantly Black community.

Dietz's (1995) paradox was utilized to inform parts of the program. This paradox was taught to be true. In fact, I think I believed it. I hadn't taken one sociology course before, so I had nothing to prove it wrong — I just questioned it in my head. Being a Black young woman with my experience and knowledge, I had a lot of questions. But being a young Black woman, a young Black female "researcher" new to the program and fresh in my career, I was also afraid to disrupt the system. That is also part of the problem: power dynamics play a huge part in each institution of Black women's lives. (Collins, 2004; Harris, 2015)

Black Women, Class and Power

There is a classist approach when it comes to programming to alleviate communities of color from various health disparities including "obesity." Kendall's (2020) Hood Feminism theory, which can also be utilized to debunk false notions built around Black women and Black communities.

As mentioned, I come from a town where I was often the only Black child in school, stores, medical offices, etc. My mother and I would often have to travel to nearby cities that had more Black people than our city for hair products, salons, and just to be around Blackness. We would go to what people refer to as "the hood." My mother often had friends and family members in these spaces. At some point in my childhood (probably around 12 or 13) my mother got concerned about my relationship with my Blackness — sounding "too white," "not having enough edginess," not having a good sense of myself or my connection to my Blackness. So one summer, I don't know how, but it was decided that I was going to spend a few weeks with my mother's friend in "the hood," a woman who did my hair growing up. She had a daughter two or three years older than me, so it worked out perfectly.

One could say “Why in the world would a middle-class single mother who worked so hard not to be associated with ‘the projects’ (as she often proudly proclaimed) send her child to stay in what society knows to be the most dangerous spaces in the U.S. America? ‘The hood.’ I first have to explain who’s care I was under. Academics would call Dellashon “straightforward,” and in the Pitts (short for Snakepit, what the local community calls this particular area) she’s respected. No one messed with her. She’s a true community pillar with a whole lot to say, when and how exactly it needed to be said. She doesn’t hold back any blows; she’s gonna give it to you straight, doesn’t matter who — child, another woman, men — she’s real and straight-up. That’s why she’s respected, a hood feminist. She looks out for her community, and the community looks out for her. She embodies community care, from selling ice cream and candy during hot summers. (In historical Black community rhetoric, she was known as “the Candy Lady.”) She babysits for other single mothers in the community. She also does hair for an affordable price for other Black women and girls in the community. Respect was there, and the main reason my mother felt safe enough to let me stay summers and New Year’s Eve immersed in “hood” Blackness. I am not afraid of “those people,” as society portrays us as. I found protection, community, friendship, love, joy, and myself in such spaces.

Kendall (2020) states:

We have to change how we talk about Blackness, about poverty, about the women who inhabit those spaces where access and opportunity rarely intersect. We have to be ready to listen to the girls and women who are still there, and not just the ones who were able to get out. We have to remember that respectability is the poisoned soil white supremacy gave us, not the hood, not being ghetto or ratchet. We have to be willing to regularly put the needs and concerns of those with the least before our comfort. We were taught to fear the impact of rejection by whiteness, to embrace their standards without giving much thought to the impact on our own well-being or that of our communities. We have to break down this conditioning, have to ask ourselves why we’re more concerned with how we are received by the white supremacist patriarchy than we are with protecting ourselves. The hood is my home, and always will be, but I am deeply aware of the way that my privilege

in being able to code-switch and to see and mimic middle-class manners has given me access. (p. 97)

Kendall's (2020) analysis is correct. We as a society have to change how we talk, write, think about Blackness and poverty, especially when it comes to "intervention programs" for health disparities. When it comes to these "intervention programs" that specifically target Black and disadvantaged communities, programs like "Let's Move" and others of the National Physical Activity Plan (a comprehensive set of policies, programs, and initiatives that aim to increase physical activity in all segments of the U.S. population to alleviate childhood "obesity"), without the knowledge of community matriarchs and distinguished leaders, what solutions are we really providing these communities, especially when speaking to Behavioral Health (public health) professionals? I'm aware of Community-Based Participatory Research (CBPR). CBPR is a great step in the right direction when it comes to inclusion of the community and assessing needs, but power dynamics with class issues are still the barrier of health-disparate interventions reaching its full potential.

I believe my childhood experience of entering these "hood" spaces — not in fear but in a realm of connecting to my own Blackness, community, and friendship in a Black safe haven from a middle-class community that didn't have the resources I needed as a Black girl growing up — worked as an asset into my time as a Behavioral Health researcher, my time in graduate school. My ability to code-switch and relatability to other children, mothers, and families really worked as an asset for the VT program I was a part of. I wasn't "scared" or "afraid" in these communities, and my white counterparts reminded me of something a colleague said while working on a community garden project in Danville, VA, based in housing authority spaces in

that community, “It’s getting dark. We should wrap up soon. I don’t want to get raped or stabbed.” Class was definitely an issue during my time on that project. I cringed in disgust at the comment yet was too fearful about the consequences of my own positionality as a Black female new to the institution and department to say something about it.

Power Dynamics

The medicalization of Blackness sustained notions of false racialized rhetoric, ingrained in society and various institutions such as medicine, sciences, and philosophy. Black bodies have been abused medically via the process of medicalizing Blackness, experimentation, written philosophies, and documentation, even the Encyclopedia. The early stereotyped grouping of Blackness, fatness, and disease lead to abuse of Black bodies such as Saartjie Baartman’s and the reproductive experimentation done on Black bodies such as Anarcha’s. The government’s hand in Black women’s reproduction (sterilizations), Black pathologies of illness, “fatness” and disease, false philosophies of pathologized cycles of “fatness,” disease, and government dependence all produced and reproduced false narratives that have always been and still are harmful to Black bodies that enter medical establishments. These false narratives are used to “alleviate” “obesity” and “sickness” in Black communities through government programs or social science interventions. Power dynamics sustain these practices.

Rebecca Skloot’s 2017 book entitled *The Immortal life of Henrietta Lacks* reveals the power dynamics between science and Black woman personhood. Skloot explains how the “history of Henrietta Lacks and HeLa cells raise important issues regarding science, race, ethics, and class” (p. 1). HeLa, the code name given to the world’s first immortal human cells — “her cells cut from her cervix just months before she died...cells from her cervix living on forever —

bought, sold, packaged, and shipped by the trillions to laboratories around the world” (pp. 1–2). HeLa cells were one of the most important “discoveries” in medicine in the last hundred years (p. 4). The history of Black female erasure, power dynamics, and nonrecognition of contributions in medicine made it okay for “science” to further the medical field without recognition of Henrietta or her body or even her existence. Her cells saved the world of medicine, but medicine and science did not care to save her Black body. The power dynamics between medical lions, science, and the autonomy Henrietta did not have over her own body highlights how bodies are seen, treated, and categorized as knowledge, “groundbreakers,” or even monumental people in history. Skloot also counts as one of the white scientists/authorities who professionally benefited from Black bodies. She became rich and famous from this book, and there is a lot of critique about what the family did or didn’t gain from their story.

Generally, Black Americans feel they participate less in their interactions and decision-making with physicians than white Americans feel, but not when their physician is of the same racial/ethnic background (Cooper-Patrick et al., 1999). Additionally, “female patients communicate more effectively with female than male physicians” (Mast, Hall & Roter, 2007). Research also suggests that health and well-being are correlated with racially concordant provider-patient dynamics (Green et al, 2003; Tweedy, 2015; Mahase, 2020).

Unfortunately, Black women may not often or ever encounter Black women doctors because of oppressive institutional tactics and perceptions built in our society that keeps Black women and people out of spaces where they can evoke their knowledge as previously mentioned (Khoury, 2020). Medical school matriculation rates among students of color are declining (Garces & Mickey-Pabello, 2015). As research suggests, if health and well-being are correlated with racially concordant provider-patient dyads (Green et al, 2003; Tweedy, 2015; Mahese, 2020),

then there should be efforts to include Black people in medical schools for the actual betterment of Black health rates and health-disparity rates. Clinicians, physicians, public health officials, and social scientists must strategize outside of traditional teachings about how providers can communicate better with patients of color and resist racial framing practices that contribute to improper diagnosis.

Asymmetrical power dyad relationships affect communication in general; when race, gender, and class are added to these dyad relationships, perceptions, bias, and/or stereotypes may affect the dialogue or behavior in that relationship. It is important to note that people can feel when you are talking to or addressing them from a biased place or a place that positions you on a pedestal to be looked up to. These asymmetrical relationships of white male doctors and Black women patients will continue until more opportunities for Black women and Black people surpass the stereotypes and ideologies of the greater society. In treatment access and opportunities for Black people, racism affects society as a whole, medical practices in particular, which mirror society's ideologies and practices in regard to Black bodies.

Dietz's (1995) paradox may not have been physically harmful to the seven-year-old girl, but she and I are probably around the same age now. The emotional pain that this case study not only has done to her but other young Black girls like us that then grow up to be Black women, makes it okay and medically appropriate for physicians as well as all institutions in society to tell us that we are "off the charts," "too big," or "something that needs to be fixed," regardless of tests indicating that we are healthy. "Fat" Black girls are not destined to be Black women that battle a future cycle of disease, "obesity," and financial uncertainty. "Fat" Black girls can heal, live healthy, happy, and prosperous lives without having to conform to Western beauty standards or the stereotypical Black female standards of having to have a small waist and big butt. Until "fat"

Black women are seen as healthy (regardless of BMI) or perceptions of weight changes, racial health disparities will continue. Weight should be looked at as (a symptom of) human diversity or a response to injustice and oppression, not stereotyped into genetic predisposition. What really needs to be in question is the structure of society. Honorable Donna M. Christensen, MD, chair of the Congressional Black Caucus Health Braintrust, has declared, “Health disparities are the civil rights issue of the 21st century.” Until we see Black women, regardless of their class, as sources of knowledge, there will be continued racial disparities throughout society.

Collins’s (1990) “Black Feminist Thought in the Matrix of Domination” discusses distribution of power in the context that we know it via the societal structure, proclaiming new knowledge as an ingredient for dimensions of change. She asserts

Afrocentric feminist thought speaks to the importance that knowledge plays in empowering oppressed people. One distinguishing feature of Black Feminist Thought is its insistence that both the changed consciousness of individuals and the social transformation of political and economic institutions constitute essential ingredients for social change. New knowledge is important for both dimensions of change. (p. 553)

Given this history of othering by white science and medicine, given the realities Black feminists have described about the ways contemporary Black women are marginalized socioculturally, sociopolitically, and economically, I hypothesize that this dynamic of white medicine pathologizing Black women is still alive and well, operating in racialized and gendered rhetoric. I am going to ask Black women if that is true. The new knowledge I hope is gained from this project is how Black women define themselves and their own bodies, Black women’s experiences around their gender, race, and weight in the context of social and medical settings,

and how medical establishments can better improve their interactions with Black women in efforts to better treat, diagnose, and care for Black women patients.

Chapter III

Methodology

Research Information and Questions

In this project I ask the following questions:

- 1) What are Black women's experiences around health, race, and body size?
- 2) How are these experiences influenced by
 - a) intimate household settings,
 - b) community settings,
 - c) social/medical settings?
- 3) How have these experiences impacted Black women's self-perception and how they navigate society, including:
 - a) intimate household settings,
 - b) community settings,
 - c) social/medical settings?

To answer this question, I developed a Gender Race Weight matrix (**see Appendix C**)

Deficit narratives

Medical and health communities tend to rely on the dependability of false theories, often adopting and applying such theories universally. These theories tend to characterize marginalized groups with deficit thinking, seeing someone in lack because their culture or way of life is different from theirs. Therefore, when exploring the experiences of marginalized groups, we find

that many of these theories, which frame marginalized groups with a deficit, simply do not hold up. The overarching goal of this project is to disrupt the spreading of deficit narratives that cause harm from the institutional to the personal level. According to Patton Davis and Museus (2019), “Deficit thinking is rooted in a *blame the victim* orientation that suggests that people are responsible for their predicament and fails to acknowledge that they live within coercive systems that cause harm with no accountability” (p. 119). They continue, “Researchers who situate people as problems engage in deficit thinking by focusing on fixing people rather than fixing oppressive and disabling systems” (p. 119). In what follows, I discuss how deficit thinking is not only a symptom of larger systemic oppression, but also reinforces these oppressive systems. Furthermore, deficit thinking is pervasive and implicit, often emerging in language that treats people as problems.

From Dietz’s encounter with the seven-year-old Black girl, the Food Insecurity-Obesity Paradox was developed. This paradox has been utilized as theory in various health programs and projects. As a behavioral health graduate student, I was told to utilize the Food Insecurity-Obesity Paradox in a project (that was never completed). This paradox is a deficit narrative. I can say this based on my lived experience as a Black woman and based on my training in Black feminisms and medical sociology. Based on Black feminisms, my experience is knowledge, and my medical experience as a Black girl coincides too well with Dietz’s seven-year-old patient. I’m using weight and size and experiences around Black women’s health care experiences to make this point.

Thick Methodology

I employ a thick methodology, meaning I employ Tressie Cottom's Black feminist theory of thick. As mentioned, and discussed in Chapter I, Cottom's 2019 text *Thick: and Other Essays*, Cottom engages in levels of thick analysis and how the term "thick" kept showing up for her as a Black woman, not only just in terms of her physicality, but even her thinking and writing as an academic. She states, "My ethnographies have too much structure, and my sociology is a bit too loose with voice. A bit slutty it all is, really, jumping between forms and disciplines and audiences. My writing has a high body count, as the kids say" (p. 27).

Similarly, when I say I employ a thick methodology, I mean an entangled, intersectional, interdisciplinary, layered, and interlocking matrix of theorizing, collecting information, and having a "high body count" of a word analysis (something that is not encouraged socially and academically). This thick methodology is suitable for this study because Black women are not a monolithic group (but often are treated as such, especially in medical settings)(Agyemang, Bhopal & Bruijnzeels, 2005). Invoking Jennifer Nash's definition of Black feminisms and the "shifting and unfolding" of Black women's experiences, the heterogeneity of Black women, therefore, requires an interdisciplinary methodology and multiple ways of theorizing Black women's experiences. In this dissertation I engage such a methodology by focusing on Black women's intersectional health experiences, and how they are impacted by circumstances resulting from their environment. I engage in this thick methodology by borrowing from Harris-Perry's theorizing of the crooked room and Ritchie's violence matrix to develop a layered analysis for examining the experiences of "fat" Black women within the "crooked room of medicine."

In addition to physicality, the term thickness can be applied to the embodiment of the unseen weight of racialized-gendered contemporary and historical trauma. I recently talked with a Black woman herbal spiritualist healer and reiki practitioner who told me that when she says, “I wish you ‘love and light,’” she is referring to not only light as in light versus dark, but light versus heavy. That stuck with me. I was at a time in my life where I felt so heavy. She states, “We often think of the opposite of light as dark, although an easier concept in terms of energy is light versus heavy. Throughout the human experience we encounter an array of energies that spark emotions. Once we become familiar with our right to choose which energies we want to carry, it becomes much easier to distinguish between the light or the heavier loads.”

When you are in the thick of things, you can’t breathe because life is throwing every curveball possible it can throw at you. I’m talking about that thick. When life punches you in the stomach and you finally rise up to breathe after being down so long with no oxygen, but as soon as you raise up a little to catch a little air, life socks you in the stomach again. I’m talking about that thick, that kind of weight. Heaviness. Weight. The type of crooked room thickness that forces Black women to try to fix ourselves in ways that are not even comfortable to us. “Dis-ease turns into disease.” The type of thickness that makes Candice Bembo proudly proclaim, “My lemonade has vodka in it.” Well, Dr. Benbow, my lemonade has Hennessy in it! (Cheers!)

For me, Cottom’s story isn’t just an individual account, but another example of the bigger social issue that I’m making efforts to highlight — the detriment of social categorization and comparing of bodies and how Black women and girls feel the need to always have to “fix” themselves to fit into a category, or crooked room. There is an impossibility to this, a futility. Cottom also explains how she was born with a slight birth defect in her feet that affects the way she walks. With a lot of training from her mom yelling, “Fix your feet,” and internalized

heightened attention, she adapted a habit of “fixing her feet.” She also correlates this analogy to Black women always having to “fix their feet” to fit into social standards. Cottom explains that fixing her feet was an “extreme maladaptation” (p. 25).

Like Cottom (2019), I engage with the levels of “thick” and how it kept showing up for her in relation to her as a Black woman. Like Cottom (2019), this work started because I kept noticing how my body was showing up in the world in relation to how my body was treated, not just socially, but in medical spaces as well. When I am engaging with the word “thick,” I am also talking about the generational burdens that Black women carry and drag along through life that are not often discussed. Black women not only face social ills, but the actual weight/heaviness and burden that we carry. The type of thick and heavy baggage that Erykah Badu talks about in her 2000 hit “Bag Lady.” She was talking about dropping all that weight, that heavy baggage.

The type of thick that doesn't fit into a box; it oozes out on the sides. The type of thick you can't breathe in because you're in the in between of past and present. I can't breathe because I'm in the diaspora as a product of the Transatlantic slave trade and middle passage and what that means for my body and women who look like me. Caught, stuck in the middle, in the in between. No matter what space my Black female body shows up in, I can't breathe, be comfortable, or be my true, authentic self without being stereotyped or poorly treated because I reside in that in-between of what my body represents in the diaspora. Being in between the historical treatment of “fat” Black female bodies and contemporary Black maternal death. Being in the in-between of refusing the term “fatness,” refusing the label “obesity,” and being me, especially in the medical crooked room where I can't “fix” myself because they want to do it for me. I also can't breathe because I'm always telling myself to “fix” myself. Fix how I walk, fix my stomach — hold it in, not too tight, you'll look constipated; fix your hair, that might be too much; fix the piercings on

your face, that might be too much for a Black woman, they may get the wrong idea. “Fix how you talk.” They are going to pay you more attention if you use the right words. Are you sure you used this word right? Fix my clothes, a “big” girl in sloppy clothes, even expensive sloppy clothes, is never attractive. Fix my tone — too loud too loud — stop yelling.

When I am engaging in the word “thick,” I’m not talking about the ’90s to contemporary music video “thick.” The thick that is not comfortable. The thick that is not “fat” but does not fit in with “thin.” The thick that needs to be fixed and shaped. The thick that you have to hold your stomach in *gasps for air* ... There you go. The thick that you gotta do more sit-ups and squats to fit in. The thick that needs to be fixed and reshaped to actually attempt to fit into spaces. This highlights the internal mental battle conversation that Black women go through when we are and aren’t “thick” (Hughes, 2021).

Needs Assessment

I come from a public health discipline centered on assessing the needs of the community. For this project, I am doing a Black feminist needs assessment of Black women’s health burdens. The literature states

Health needs assessment is the systematic approach to ensuring that the health service uses its resources to improve the health of the population in the most efficient way. It involves epidemiological, qualitative, and comparative methods to describe health problems of a population; identify inequalities in health and access to services; and determine priorities for the most effective use of resources. Successful health needs assessments require a practical understanding of what is involved, the time and resources necessary to undertake assessments, and sufficient integration of the results into planning and commissioning of local services. (Wright, Williams & Wilkinson, 1998, p. 316)

The “health needs assessment” process needs to take account of the diversity within minoritized and otherwise marginalized populations (Bani, 2008).

My dissertation is a needs assessment because of the following: I propose a lens to analyze Black women's health in regard to race, body image, and medical spaces in a holistic way. I will be using qualitative data techniques such as Black feminist qualitative research (Patterson et al, 2016; Clemons, 2019). These techniques are suitable for a project such as this because while health problems and inequalities for Black women have already been well documented (Chinn & Redmond, 2021), there is little documented from Black women's own experiences. I have identified weight as my focal point as it pertains to Black women's health; therefore, I will utilize my interviews to reconceptualize Black women's experiences in regard to race, body image, and medical spaces.

Through my own experiences as a Black woman, I am also not acting as an expert but as a person who is interested in the co-creation of knowledge through a willingness to thoroughly investigate and listen to interview participants toward developing a deep understanding of the topic.

Gender Race Weight Matrix

I employ a gender race weight (GRW) matrix for this project. This matrix builds on Ritchie's violence matrix as explained in her 2012 book *Arrested Justice: Black Women, Violence, and America's Prison Nation*. There, Ritchie looks at forms of oppression that lock the systematic abuse of Black women in place in regard to violence and structural disadvantage. Ritchie's matrix is divided into three levels: intimate household, community, and social sphere, and at each level she specifically focuses on physical assault, sexual assault, and social disenfranchisement.

Pulling from Ritchie's matrix I have similarly focused on the three levels of intimate household, community, and the social/medical sphere. (I specifically added the focus of medical spheres to the social level.) My approach will be chronological and focus on the gender, race, and weight of the participants past, present, and future (**see Appendix C**) to develop a GRW matrix, which examines the various influences that can impact women in terms of gender, race, and weight. My theory moves toward a more complex understanding of Black women's health that I hope will promote healing rather than a deficit narrative. The goal of the needs assessment from my experience and from the literature could be several things that may or may not promote healing.

Like Ritchie's violence matrix (2012), I looked at similar social levels/settings of experiences of Black women. However, instead of focusing on levels of assault and violence as Ritchie does, I asked questions based on chronological order. Including the experiences of Black women (past, present, and future) in tandem with their experience navigating their identities specific to their gender, race, and weight, those in tandem with their experiences in their own bodies as Black women in social and medical spaces as it pertains to gender, race, and weight. Finally, the matrix will act as the guide for how I formulate my data collecting instrument, where questions are broken down into subsets based on the three domains of intimate household, community, and social sphere.

Social levels/settings

Intimate: parents, guardians, household members, family, grandparents, spouses, intimate partners

Starting with the intimate household and past experience level, I asked participants questions about their past experiences with their gender, race, and weight in intimate household settings including, but not limited to parents, guardians, household members, family, grandparents, spouses, and/or intimate partners; themes will include past household/generational habits/beliefs/ideas in relation to gender, race, and weight. Intimate household and present experiences will focus on current experiences with gender, race, and weight and how past experiences may have impacted present. The present column of the matrix will function as a reflective component/interview question. This column is important because reflexivity is an important and essential component of Black feminisms' methodologies. Themes in the intimate household/present experience section focus on current coping habits from past experiences, how past affects current life, generational habits/coping skills, generational health issues or symptoms. The last intimate household section of questions focus on future actions/attitudes/goals in regard to gender, race, and weight for participants and their intimate households. Themes in this section focus on if participants are or plan on breaking cycles from past/generational ways of coping with life (binge eating, bulimia, etc.) to more holistic (steering away from the word "healthy") balanced habits.

Community: neighbors, neighborhood, residential, school, friends, classmates, community orgs/spaces, community leaders, authority figures, neighborhood friends, work environment, coworkers

The next section of the matrix is the community level/setting focusing on past, present, and future experiences of Black women as it pertains to their gender, race, and weight. The first column focuses on past community experiences. Themes in the section focus on past community habits/beliefs/ideas of GRW and "thick" Black woman(girl)hood. The community and present

section focuses on current community experiences with gender, race, and weight and how the past may have impacted the present. Themes in this section include reflection of community/workspace affirmation of Black womanhood. The community and future section focuses on future actions/attitudes/goals for their community spaces/friend groups/organizations/networks in relation to gender, race, and weight. Themes in this section focus on future goals/attitudes/actions to affirm Black womanhood (live in/move to spaces that affirm) and “thick” Black womanhood.

Social/Medical: media, social media, social media networks, public spaces, public agencies, social services/government spaces, medical spaces, urgent care.

The social/medical settings and past section focuses on past interactions/experiences with social and medical spaces with gender, race, weight. Themes in this section zero in on past misunderstandings/stereotypes/miscommunications with medical or social spaces due to being a “thick” Black woman/GRW. The social/medical and present section focuses on current relationships with social and medical spaces regarding gender, race, and weight, as well as the past’s impact on the present. Themes in this section include misunderstandings/stereotypes/miscommunications with medical or social spaces due to being a “thick” Black woman/GRW. The social/medical and future section focuses on future actions/attitudes/goals with medical and social spaces regarding gender, race, and weight. Themes include goals, plans to seek medical care, and social spaces (including social media spaces) that affirm or are knowledgeable about the experiences of Black womanhood and holistic health considerations/goals/beliefs/attitudes.

The matrix-guided data generated by my interviews gives me as a researcher and a Black feminist public health needs assessor the ability to critique the crooked room of medicine, the generational impact of crooked rooms, and not only medical but other social spheres as well and how crooked rooms collide.

I introduce the GRW matrix to this discussion of Black women's health experience in the crooked room. Crooked rooms create and compound health disparities and morph peoples' experiences, creating the complicated GRW matrix I am introducing. Within this matrix a multitude of circumstances exist. I argue that Black women may suffer from a higher weight-related health-disparity rate compared to other women in the U.S. due to the impacts of systemic oppression, bias, and unequal treatment (Williams & Sternthal, 2010; Anderson & Massey, 2001; Oliver & Shapiro, 2006; Chinn, Martin & Redmond, 2021). Therefore, weight might be a symptom of the stress of navigating social ills for Black women. There is plenty of research that links stress to weight, stress of racism to weight, etc.

As noted in Chapter I, Black women are not a monolith. Fluctuations in weight depend on the woman, but commonly it might be a symptom of living in a racialized, gendered society rather than being a symptom of genetics. The matrix considers the intersections of marginalized experiences (internalized oppression, self-hate, eating disorders, addictions, etc.), and oftentimes the "normal" indicators of "obesity" have nothing to do with weight at all. In fact, they can be a circumstance of environment, so focusing solely on weight for certain bodies does a disservice to those bodies when they enter medical spaces.

The heaviness of generational racialized trauma in lieu of contemporary lived experiences for Black women can cause detriment to the mental psyche. If that is not actively being healed or

talked about in a healthy manner, mental unrest will show up in the physical form, therefore causing physical heaviness or illness. On top of Black women's other daily responsibilities/tasks/routines and experiences, this can cause a matrix of circumstances. Dis-ease turns into disease.

Embodiment of (generational) heaviness

I argue that weight is a symptom of social and structural oppression in regards to Black women's health. Stress from societal structural oppression can cause weight gain/loss; therefore, weight is a symptom rather than a genetic racialized gendered identity or deficit disease (i.e. hypertension, diabetes, high blood pressure, heart disease), many of which are framed as Black issues. Research shows racism affects stress; therefore, racism is a public health crisis, especially for Black women, and the effects of navigating such spaces for Black women have been passed down for generations (Afua, 2000). Therefore, I also argue that within this matrix there is a proposed circumstance of embodiment of (generational) heaviness in regard to Black women's health and weight.

Chrisley & Ziemke (2006) define embodiment as

an understanding of how cognition is realized or instantiated in a physical system, especially a body, may require or be required by an account of a system's embedding in its environment, its dynamical properties, its (especially phylogenetic) history and (especially biological) function, and its nonrepresentational or noncomputational properties.

The mental ramifications that our foremothers had to endure within colonized spaces more than likely caused traumatic stress that has been passed down from generation to generation. As previously mentioned, stress attacks the body and manifests as disease. Imagine the detriment that enslavement did to the mental psyche of an enslaved woman, which was then passed down to

Black women in the Jim Crow era, then to Black women in the Reconstruction era, and continued with Black codes, the War on Drugs, and mass incarceration. That is a lot of heaviness. Where does that leave the physicality of the Black female body and the contemporary health of Black women as a collective?

Intergenerational trauma is when “children contain the unassimilated trauma of their parents, and often grandparents and beyond” (Grand & Salberg 2016, p. 11).

Doucet & Rovers (2010) argue:

The effect of traumatic stress upon the next generation has not been steadily addressed. The phenomenon of generational trauma as a secondary form of trauma that may be passed down to subsequent generations through various means of psychological transference is reviewed by means of attachment theory. Spiritual/religious forms of interventions may be of help in mitigating the harmful consequences of severe trauma in the lives of trauma survivors and its generational effects in the lives of their offspring. (p. 93)

I argue that this trauma becomes heavy emotionally and oftentimes manifests into physical heaviness, i.e. weight — the embodiment of heaviness. Shantrelle P. Lewis’s 2021 Netflix documentary *In Our Mothers’ Gardens* celebrates the strength and resiliency of Black women through the complex relationship between mothers and daughters. The documentary also pays homage to Black maternal ancestors with discussion of generational healing for Black women.

Data collection method

Approach (qualitative, feminist qualitative)

I conducted an exploratory study about how body size, race, and gender intersect in social and medical encounters, as well as about the ways those experiences and feelings linger for many Black women. Through a qualitative phenomenological framework, my study investigated the

implications of race and gender, at a specific point in time, for African American women. My approach to collecting the data is qualitative, specifically feminist qualitative data collection and methodology.

Feminist research is described in terms of its purposes of knowledge about women's lives, advocacy for women, analysis of gender oppression, and transformation of society. Feminist critiques of social science research are reviewed in relation to the development of methodological and epistemological positions. Feminist research is viewed as contributing to the transformation of science from empiricism to postmodernism. Reflexivity, collaboration, power analysis, and advocacy are discussed as common practices of feminist qualitative research... Validity and voice are identified as particular challenges in the conduct of feminist qualitative research. Intersectionality and double consciousness are reviewed as feminist contributions to transformation of science (McHugh 2014, p. 137).

Interviews were conducted between January and March of 2022. While it is desirable for interviews to be conducted in-person, circumstances do not always allow for this and some participants may find a phone or video call more convenient. Given that my own social network is spread throughout the U.S., that the global COVID-19 pandemic continued throughout the months of my data collection, and that I employed the method of snowball sampling, the majority of my interviews were not conducted in person. Additionally, given current physical distancing recommendations, video and phone interviews were the most viable option for the duration of this project.

For those participating in face-to-face interviews, quiet and confidential locations were offered. In-person interviews were recorded with a digital audio recorder while phone interviews were recorded with TapeACall Pro. TapeACall Pro is an app that allows you to record an entire phone call. The audio file can then be transferred to a secure storage location. For video calls, Zoom was utilized. Zoom also allows the facilitator to record the video interview in its entirety.

Audio files from all interviews were transcribed using Transcribeme transcription services. Interviews are expected to last one to two hours but may vary among participants.

Recruitment

Participants, sampling, and recruitment strategy

For this study I interviewed participants who range from a diverse group of Black women. Recruitment for interviews were carried out via flyers (social media), email solicitation, word-of-mouth, personal networks, and direct recruitment via announcements.

Sample strategy used for this project was snowball sampling. Individuals who meet the criteria are part of a diverse group of Black women who have had intimate, family/community, and society experiences, including within the medical profession, and the ways in which this shapes their relationship with their bodies. In sociology and statistics research, snowball sampling is a nonprobability sampling technique where existing study subjects recruit future subjects from among their acquaintances. Snowball sampling is a commonly employed sampling method in qualitative research, used in medical science and in various social sciences (Noy, 2008).

Once potential interview participants were identified, they were contacted via email. If individuals chose to opt in to the study, I reached out to schedule an interview for a time and date convenient for them. While this sampling strategy is likely to draw particularly motivated interviewees, this is reasonable for an exploratory study so I generate initial findings and generate further questions from those findings that I then generalize to a larger population.

When interviewing, Guest, Bunch & Johnson (2006) suggest that saturation is often reached within the first 12 interviews. Saturation is often described as the point where new

information no longer emerges from added interviews (Guest, Bunch & Johnson, 2006).

However, they also note that this concept is rarely operationalized by researchers. They argue that saturation can be determined by examining codes. At the point where no new codes emerge, it can be assumed that saturation has been accomplished (Guest, Bunch & Johnson, 2006). Based on these assertions, I interviewed 12 participants who identify as Black/African American.

Table 1: Participant Information²

Pseudonym	Race	Social Class	Location
Akua*	Black/West African	Middle class	East
Ashley *	Black	Upper middle class	Southeast
Billy*	Black	Upper middle class	Midwest
Candice *	Black/Nigerian	Middle class	South
Casey*	Black	Middle class	East
Daisy	Black	Middle class	South
Diane	Black	Middle class	Southeast
Elizabeth	Black	Middle class	Southeast
Kae	Black	Middle class	West
Michelle	Black	Middle class	Southeast
Paula	Black	Middle class	East
Tammy	Black	Middle class	East

*= have or are currently pursuing doctoral degrees

Recruitment Questions

- Are you a Black woman who struggles with body image issues?
- Is this related to your experiences with medical professionals?

² Education is being used as a proxy for class

- Would you like to talk to a Black feminist researcher about your experiences?

Semi-Structured Interviews

I conducted semi-structured interviews to gather this exploratory data. A semi-structured interview is verbal interchange where the interviewer attempts to obtain information from another person by asking questions. Although the interviewer prepares a list of predetermined questions, semi-structured interviews unfold in a conversational manner offering participants the chance to explore issues they feel are important. Semi-structured interviews are informal in tone and allow for open response in the participants' own words (Longhurst, 2003).

Semi-structured interviewing aligns with Black feminisms epistemologies and feminist qualitative research, centering Black women's experiences as knowledge in aim of social reform and reflective awareness. "Various forms of interviewing have long been used to bring people's experiences forward and make those experiences visible in more public discussions, and such projects have often been conducted with the aim of social reform" (Devault & Gross, 2011, p. 5). Intentions for this project are aimed at medical and social reform regarding Black women's experiences.

Brinkman and Kvale noted in 2008 that interviews allow participants freedom of expression in telling their stories. In her later work, Brinkman (2013) also concluded that interviews "open up intimate aspects of people's lives" (p. 149) and do so in ways that are often overlooked. The semi-structured interviews for this study assist me in understanding the feelings and intentions that influence participants' actions and behaviors. Noted by Bogdan & Biklen in

2002, the interview (as a data collection method) is used to gather descriptive data in the participants' own words so that the researcher can develop insights on how the participants "interpret some piece of the world" (p. 96).

Interview Guide

The interview instrument was structured around the GRW matrix (see Appendix) in that interviewees asked questions about their experience from past, present, and future actions/attitudes/goals on the social levels of intimate households, community, and medical/social settings. My project is about the lived experience of the race/gender/weight matrix in the contemporary U.S. My interview questions are structured to elicit this information.

The questions are open-ended and flexible. In these interviews I asked participants questions about racial generational trauma, mental health, how their interpretation of how these experiences may affect their body image, and how they see themselves in society. Sample questions include reflexivity for past-to-present experience analysis. All interviews were audio and/or video recorded for the researcher's analysis so the discussion can flow more as a conversation than an interview. I did not actively take notes; however, if the conversation sparks "key words or phrases," I had a pen and paper aside during the discussion to note such words or phrases.

Consent, Confidentiality, etc.

Prior to the start of any recording, participants read an informed consent form where it would be made clear to interviewees that their participation is entirely voluntary. The structure of the interviews was corresponded as a semi-structured interview protocol, whereby guiding

questions are utilized while allowing room for probes and conversation (Brinkmann, 2014). Guiding questions are included as appendices to this document. Few risks have been identified. The potential risks to study participants are minimal; however, participants may experience negative emotions when answering particular questions during the interview, particularly as they recall certain aspects of their lives, circumstances, and/or medical encounters. Interviewees were allowed to choose a pseudonym for themselves; they are referred to as such in my dissertation, noting that confidentiality were maintained.

Data storage

I collected name and contact information for study purposes, but I stored any identifying information including digital data on a separate drive in a locked file cabinet to which only I have access. Identifying information was stored in a separated locked file cabinet from notes and transcripts. In addition, any identifying information was removed from notes and transcripts and chosen pseudonyms were reported in the data. At no time did the researcher release identifiable results of the study to anyone other than individuals working on the project the Virginia Tech (VT) Institutional Review Board (IRB) may view the study's data for auditing purposes. The IRB is responsible for the oversight of the protection of human subjects involved in research.

Data analysis

Christina Sharpe's 2016 book *In the Wake: On Blackness and Being* discusses wake work as a praxis of care. "To care" is the central part of wake work, also described as a Black feminist ethics. It is to (at)tend to Black life, Black beings, and Black lives, however and wherever they appear. It is to be concerned for Black folks' health. It is to breathe life into the unnamed and unknown Black bodies of the past. This project is a dedication and acknowledgement of the harm

done to Black bodies and women in the Diaspora, especially those who have suffered and died in the CRoM. This project utilizes Sharpe's (2016) wake work methodology and analysis while examining and researching Black lives, experiences, and history in CRoM.

Wake work requires we become undisciplined as scholars to enact "new modes and methods of research and teaching" (p. 13) what she calls "Blackened knowledge," and "unscientific method" (p. 13). Black feminist research is done with care and purposeful intention, and that care and intention has to be done twofold — for the researcher and the respondent. The work is heavy, and care is important at both ends because that heaviness is also transcendent. Therefore, a level of intention needs to happen for Black women researchers in the academy researching about Black women. The wake work that I am utilizing to challenge the ideas of how Black women are treated in medical spaces is acknowledging those harmed and deceased in the CRoM, applying intentional care with this project's participants, and intentional pre- and post-care for myself. Sharpe states that "theorizing wake work requires a turn away from existing disciplinary solutions to blackness's ongoing abjection" (p. 33). That was my intention when starting this project with the Dietz (1995) theory, which was so off and dangerously inaccurate about Black girls and women's lives. A theory that did more harm than help. My theorization of CRoM, GRW matrix, embodiment of (generational) heaviness has been an intentional examination of care, zeroing in on stories and experiences of Black women and girls whose narratives have been altered and erased with omitted information and false narratives by colonization.

Sharpe (2016) also introduces the practice of Black annotation and redaction as more examples of wake work. She asserts, "It again became clear to me that so much of Black intramural life and social and political work is redacted, made invisible to the present and future,

subtended by plantation logics, detached optics, and brutal architectures. There is, in the Black diaspora ... a long history of Black life, of Black lives being annotated and redacted. There is, as well, continuous resistance to and disruption of those violent annotations and redactions” (Sharpe, 2016, p. 114). I use Sharpe’s (2016) work and recourse of Black annotation and Black redaction as a part of the methodology and analysis of this project.

My Healing Practice as Research

While moving through my own healing journey, I met Robin, who I also do soul healing sessions with. We decided to work together to create the love self-care kits for my participants. After telling her about my project, the original plan was to have intentional items in the boxes. As we discussed what would go in them, we talked about what each aspect of healing and purpose each item addresses: moonstone candles for the healing of feminine energy; rose quartz crystals for healing of the heart; reflection journals to process emotions; chamomile tea, which has throat chakra healing when telling your truth; and mugwort tea to help with solar-plexus healing, stir up willpower, and intuition. I use (and needed) all of these things to heal my inner world and was willing to share my process with other Black women. This was the original plan until Robin noticed her own suppressed trauma from her medical experiences surfacing after talking with me. She said, “I can't just leave these women with a candle. I think it would be appropriate if they talk to me afterwards to know what to do with the energy that will be released in their body after speaking with you.”

The care I showed and provided for my participants was purposeful and intentional, not only in that my target population is Black women, but also because it was my own healing and love that I was searching for. With my personal experiences and daily accounts as a Black woman

I can attest to the daily obstacles because intersectional identities of gender, race, and oftentimes weight stereotypes come before my humanity.

At the time I began my own self-healing, this project was really starting to come alive. Going through this self-healing process, I started to look at things differently and realized that most of my epiphanies, or “ah-ha” moments, were found when in community or working simultaneously with other women as part of their own process of healing. I also wanted to share those same moments that I oftentimes had alone or with other women. The experience is even more powerful when I am able to meet and share with other women the power of true self-love and healing. This is where that research, Black feminist praxis, spirituality, and scholarship (Sharpe, 2006; Dillard, 2012; Atta, 2018) meet.

Each step of care in this project was intentionally placed and planned for because 1) while exploring the history of research and Black people in the U.S. (Washington, 2006), I became heavy from that transference of energy while just reading these things and started carrying these burdens on top of my own. I was searching for major healing and energy shifts within my own body. Given this history, my specific demographic deserves intentional care in the dynamics of research; 2) again, with my own experiences, I can attest that suppressed trauma, especially for Black women, needs special care. I recently participated in a research project regarding mass incarceration, families, and COVID-19. There was no communication of appreciation or thank you after that experience, making me exploited and uncared for. I would never want someone to walk away from my project feeling like that, so my intention for this section of the project was to let my participants know they and their stories are and will be cared for. I was also intentional about wanting to spark healing with so much care and love into my participants’ self-care kits because 3) when asking folks to recall racialized and gendered experiences that may have induced

trauma or even “undiagnosed” trauma, these recollections of experiences should be handled with care.

Interviewing Methodology and Incorporated Healing Practices

In my own healing journey, I was introduced to lapis lazuli and sodalite crystals. These two crystals sat between myself and the women I interviewed. They helped the energy transfer, and with the communication and flow of the interviews. Known as the “stone of queens,” lapis lazuli assists with intuition and clarity. This helps me remember my queenship when the world tells me I am not a queen. Lapis lazuli is said to help create and maintain a connection between the physical and celestial planes, creating a strong spiritual connection. Also known as a stone that helps with writing, it can be used for automatic writing (chakrazulucrystals.com). Many say that people who feel connected to lapis lazuli often have legacies that trace back to Egypt.

The sodalite crystal helps with logic, understanding, truth, and communication. It encourages being true to self and standing up for your beliefs. A stone of self-expression and confidence, sodalite can aid in issues of self-worth, self-acceptance, and self-esteem, as well as promote intuition and a trust in one’s own judgment, which can be a great ally in daily life. Sodalite helps to achieve emotional balance, releasing old conditioning and programming of the past that no longer serves. It is also a stone of the intellect, enhancing understanding of difficult concepts, and enhancing respect and compassion in ourselves. These crystals were important, as I know my past experiences and trauma have hindered my voice and stifled me from speaking my own truth, which unfortunately is a common experience for Black women (Jones & Shorter-Gooden, 2009). Therefore, these stones were intentionally included in the interviewing process to assist the interviewees with speaking their own truth with confidence and clarity.

Praxis and Methodology meets Spirituality and Wake Work

Before each interview, the space was blessed and prayed over with dragon's blood sage to remove any negative or stagnant energy. I did the first interview on campus, but it did not seem like a safe space as a Black academic in an already uncomfortable environment. I did not feel like I would be able to talk freely and that might set the tone of the interviews. I wanted my interviewees to speak freely, feel comfortable and use profanity if necessary. So most interviews were conducted from my home via Zoom. Intentions were set with a white candle situated close to my sodalite and lapis lazuli spheres. (After the fifth interview, rose quartz crystal was added to the setting to bring forth love.) This purposeful setting set the atmosphere and mood for both interviewer and interviewee, allowing them to share their truths and have that energy supported. After each interview, I purposely tried to connect with nature: a walk in the park, touching a tree, or dancing. Many of the experiences and stories shared were heavy, so it was important for me to move that heaviness. Trees have healing feminine Mother Earth energy, and it was particularly important for me to connect with one and ask it to take some of the heavy energy I might be carrying (I picked the biggest tree in the park.)

This method of collecting data was not only a self-care practice for my participants; it was for me as well. As I packed self-care boxes for the participants, I was packing love and intention, which was a therapeutic process for me. I knew that I was sending love and care to another Black woman, especially after bringing up old trauma or experiences they may not have thought about in a while. My hope was that this study would become a step in participants' healing processes or journeys, particularly if they hadn't started one, and my care package would give them some tools and reflection.

Transcription and Coding

The interviews varied from 45 to 77 minutes. Audio files from all interviews were transcribed by the primary investigator or Transcribeme, a professional transcription service. Transcribeme's online policy states that all professionals working on submitted transcripts sign strict confidentiality agreements. Additionally, transcripts and audio files were kept in secure locations accessible only to the researcher, adhering with VT's IRB protocol. All interviews and incident reports were coded using Dedoose qualitative analysis software. Open coding was utilized to categorize recurring themes emerging from the transcripts (Bailey, 2007; Creswell, 2013).

Research positionality, bias, reflexivity

I am aware of what's called the "deficit narrative" about oppressed communities like the one with which I'm working. I do not want to simply open up and then reify the experiences of trauma and marginalization without simultaneously recognizing the strength, creativity, flexibility, and joy with which Black women live in their bodies, "fat" or otherwise. This is a Black feminist project, with the core principle of centering Black women's experience and giving them the space to think and speak; I am a qualitative researcher and also a Black feminist who is engaged in this struggle alongside the research community that I'm planning to involve. Because of this, I shared my own experiences with participants, not simply "extracting" from them. I also made sure to share only when appropriate and not too much where it could overshadow what the interviewee was disclosing to me. This is the theory of "undressed/naked" vs. partially dressed vs. fully clothed (Aldrich, 1989).

Incentives for participation

Upon completion of the interview, participants were given healing kits from reiki practitioner Robin Friend's company ElevenEleven Candles & More and Jasmine Abney's company Self-Centered. These are both Black women who have businesses centered in the health and healing of women. This is intentional in two folds: as mentioned before my project is about healing Black women, not "fixing obesity"; I also do not want to simply open up and then reify the experiences of trauma and marginalization without providing resources of healing. I also provide my participants with a website that has a list of Black women owned health resources. By providing these healing kits and resources to participants I am also supporting and spreading word of the Black women's businesses in this work.

Healing not to "fix feet"

My project is not about Black women "fixing their feet" but about Black women healing. In Evans, Bell & Burton's 2017 book *Black Women's Mental Health: Balancing Strength and Vulnerability*, they expand on the notion of healing and what that means for Black women.

The term healing is purposefully chosen as a component of the model because "health" cannot occur without it. Health is not something one has or does not have; it is a constantly evolving process. Black women are in a perpetual state of healing from specific experiences of trauma such as abuse and degradation as well as from global experiences of racism, sexism and economic disenfranchisement (p. 6).

Holism and Black women's health

I argue for holistic health, especially regarding Black women's health. Applied to health care, holism is the art and science of caring for a person in a way which considers all aspects of their body, mind, spirituality, and emotional state in relation to "[other] individuals, the environment, or populations, either separately or in various combinations" (Lawrence, 1998; Iqbal, 2013). The idea that each human being is composed of physical, mental, emotional, and

spiritual dimensions is not a new concept. Supported and researched through disciplines ranging from physics to medicine to spiritualism, holism is the belief that a person is composed of several different aspects, and each aspect interrelates with others (Dale, 2009). This needs assessment project also highlights the critique of the crooked room. My hope for this project is to focus on as a critique of Fat Studies and CRoM, an intervention to sustain Black women at all levels of the matrix, and the true meaning of health, including spirituality, which is often left out of Western European medicine.

The result of Black women's disproportionately poor health outcomes is a result of a complex environment of barriers, from quality health care to racism, and stress correlated with the distinct social experiences of Black womanhood in U.S. society (Chinn, Martin & Redmond, 202). The heaviness of the past generational racialized trauma is still in our DNA (Degruy-Leary, 2017), especially for women, as when we are born, we already have all of our ova. In our mother's wombs, we sit in whatever emotions she is feeling while pregnant. That somehow gets transferred and passed down from generation to generation. Therefore, we are the walking experiences of our past and present.

I encourage Black women to aggressively search for health resources that address and take into consideration broader aspects of health. I advocate for holism for Black women's health because of its incorporation of the spiritual aspect. When I refer to the embodiment of (generational) heaviness and healing generational trauma, I am indirectly discussing the spiritual aspect of Black womanhood. I argue for holistic health resources for Black women's health due to the meeting of the spiritual and physical in relation to health. Unhealed generational trauma can affect the mental health therefore the physical health; specifically in this case Black women, as the physical, mental, emotional, and spiritual systems all interconnect and link, as previously

stated. Black women often neglect their own mental health due to oftentimes not having time or resources to support it (Bacchus, 2008; Spates, 2012). Formerly incarcerated Black women oftentimes have to hide their mental health issues to stay under the radar from the state taking their children (Gurusami, 2019); therefore, mental health goes untreated. As I have previously argued, mental unrest and heaviness manifest into the physical, creating dis-ease. Furthermore, when Black women enter medical spaces, instead of assuming the disease of “obesity” and conversations of losing weight, a holistic medical approach would better serve us as a population.

Racism and gender discrimination have profound impacts on the well-being of Black women. I argue for a holistic health treatment that addresses mind, body, emotion, and spirit to drop generational trauma baggage and weight that may manifest to physical weight, or weight around the womb??? to address “obesity” regarding Black women’s health concerns and experiences. I argue for Black women’s knowledge of health and healing in relation to Black women, weight, and medical space. Black women can and should learn from other Black women about stress associated with the distinct social experiences of Black womanhood in U.S. society as well as medical information if chosen to do so.

I argue for the concept of healing for Black women’s health as a means to dump some of the embodied (generational) heaviness in regard to the GRW matrix. Healing racial trauma is challenging because racial wounds occur within a sociopolitical context and on a continuing basis. The current definitions of “trauma,” “traumatic stress,” and “trauma treatment” are embedded in European perspectives (Hernández-Wolfe, 2013). Consequently, many trauma and PTSD treatments tend to lack cultural relevance for most POC (Bryant-Davis & Ocampo, 2016; Hinton & Good, 2015; Hinton & Lewis-Fernandez, 2011). Therefore, I do not propose just any type of healing program from trauma. I suggest holistic healing health programs centered from

Black women's knowledge for Black women's health. These resources are not going to be easily available or probably recommended from Eurocentric medical spaces. I suggest healing, not just for Black women "to drop the weight," but for the overall health of Black women because it is not about the weight but rather the health. Therefore, this project is not about "fixing" Black women or their weight, but rather healing for our health.

The knowledge that Black women have is important to this work. My experience as a Black woman has shown me that navigating through colonized spaces requires a bundle of resources for the mental psych alone.

I know too well what it feels like to feel heavy and weighed down by burdens and circumstances that feel out of control. You feel you can't get a hold on, so all you can do is stress eat and cry. I know how heavy it feels to be in the "thick" of things and how the weight of it takes a toll on your body. I'm too familiar with this heaviness, eating to fill a hole, eating to numb out, not knowing that I, too, was carrying generational heaviness. So now I am laying it all out there to dump this heaviness and never have to pick it up or continue to pass it along to the next generation again. I want the same for other Black women. Black feminism and health centered on Black feminisms is a tool that gives Black women their power back to feel control in chaotic morphed, thick, layered, and complex crooked rooms. Love and light (light vs. heavy).

Chapter IV

Results and Discussion

The findings from my study were so thick that it has felt impossible within the parameters and limitations (words and time) of this dissertation to address the full complexity and nuance of everything discussed outside of the realms of the CRoM. However, what did arise were the ways in which the medical industrial complex has impacted and continues to impact Black women in particular, and how Black women are trying to navigate, exist, and heal through all of society's crooked rooms. I recognized many emerging themes throughout the interview process, including poverty and beauty; we discussed how childhood affects us and how parents/family comments on our bodies have and continue to make us feel. However, one theme that continued to come up for each participant was healing. In this chapter, I will focus on healing because along with being a repeated talking point for all the participants, it is the foundation of Thick Studies to help counter the harm false and deficitant narratives of Black girls and women have done.

As mentioned in Chapter 1, the CRoM highlights the historical dehumanizing medical treatment of Black women's bodies that has impacted their contemporary health and treatment. Each crooked room is shaped differently, such that each of the participants' stories were very different. The differences in their stories are shaped by their lived experiences navigating society as Black women. In this chapter, I will share some of the differences and similarities of these women's experiences with the CRoM and how they incorporate healing after these experiences. The beginning of this study was informed by my own experiences with the medical system. I expected to hear similar, or close to similar, stories to mine. What is clear, as I conclude my research, is that Black women, regardless of their weight and socio-economic background, have endured and continue to endure traumatic experiences in the CRoM.

In the next section, I will be sharing the medical experiences of the women I interviewed. As detailed in Chapter 3 methodology, I utilize Black feminist Chrisitna Sharpe's (2016) methodology of Black annotation and redaction to analyze this project's findings. Out of the twelve women that I interviewed, I focus on these five stories/experiences to show that these stories are important to demonstrate and focus on Black women's contemporary experience and navigation with CroM. Not to say the other stories were not important, but these five stories have something to say to the theoretical framework and importance of this project.

Black Women's Stories of Medical Experiences

Diane's Story³

Diane's story explains her experience at her OB-GYN to have her IUD removed. She and her husband had decided to start trying to have a second baby. She describes the disconnect she has always felt between her lived experience and society in regards to her weight:

Because my family is plus-size women, it's a crazy feeling to be raised to feel like you're okay, and the world makes you feel like something is wrong with you ... I'm overweight, but I am not unhealthy; I have *no* medical issues ... This is a very sensitive topic. I never experienced discrimination in the medical field until about four years ago ... Now I can say this: I have yet to successfully go back to my doctor for a visit because it's still traumatizing. . .

Diane explained that her negative experience took place when she went to her doctor's office for a visit. The doctor was out, so she was seen by one of her doctor's colleagues, a nurse practitioner. After the birth of her son, she really committed to her health journey. When she had her son she weighed 325 pounds (the highest she had ever been), but by the time of her next

³All names are pseudonyms that were chosen by my interviewees. .

appointment she was around 250 pounds. At the time of the appointment, she and her husband had just bought a house, and during that stressful process she had gained some weight; at the time of the doctor visit she was about 275 to 280 pounds. After Diane told the nurse practitioner that she wanted to take out her IUD, the nurse practitioner simply repeated, “Take it out?” and left the room. She was gone for a while and then came back with a brown paper bag containing birth control pills. Diane stated that she did not want birth control pills; she wanted her IUD out so she could have another baby. The nurse replied sternly, “Not on my watch,” and continued to say, “You are too big to be having a baby.” Holding back tears, Diane says, “I knew it was a sensitive subject because I usually did not have problems with confrontations ... I found myself trying to convince this lady that I’m okay.” The nurse practitioner repeated, “You won’t have a baby on my watch; you are too big!” Diane responded, “What do you mean? I may have gained a little weight from buying a house. That can be stressful.” The nurse practitioner told her, “Well, you can make an appointment to come back and see Dr. Lee, but not today, not today!”

Diane described begging her provider at this point, telling her, ““If you look at my chart, you can see I’m healthy. With my last son I was 300 pounds, and I had a healthy baby; don’t you see that in there? Don’t you see that in the records?” That was traumatizing.” As she wiped her tears, Diane reflected on her experience, stating, “I could not stop crying. ‘Here we go again.’ I am telling myself that I am okay, and the world is telling me that I am not.”

Due to racialized, gendered, and eugenicist attitudes that are still present in the medical field, Diane’s story illustrates how the large Black female body is automatically interpreted as unhealthy, diseased, and unfit to reproduce. (I discuss the pathologization of the large Black female body in Chapters 1 and 2.) Diane mentions how she just bought a house, how stressful that

can be, and how that contributed to her weight gain, but she was not seen or heard by her health-care provider.

Not only did the nurse practitioner (NP), or clinician, neglect to look at her whole health record before she made stereotyped assumptions of Diane's health, she also made condescending comments based on those stereotypes. This story is reminiscent of Dietz's deficit narrative and illustrates the pathologization of the large Black woman's body and issues of medical "authoritative power" when encountering certain patients. What gave the clinician authority to display a lack of "bedside manner" and to say, "You are too big"? If the NP did not feel comfortable taking Diane's IUD out, all she had to say was, "I would feel more comfortable if you had this conversation with Dr. Lee; let's look at his schedule and make an appointment when he gets back." The nurse jumped to the conclusion that Diane was not healthy, assuming a certain size means a certain health. For five of the twelve women interviewed, OB-GYN offices were where a majority of the conversations of weight came. This has eugenicist implications and undertones, underscoring the U.S.'s history of correlating Blackness, fatphobia and unhealthiness with such mindsets.

Diane's story illustrates one Black woman's struggle to find an upright position in a crooked room. She was trying to convince her health-care provider that she was healthy regardless of her weight and size.

"Here we go again. I am telling myself that I am okay, and the world is telling me that I am not." Diane's words will forever stick with me. I, too, know that feeling. Despite the evidence, or how Black women feel themselves, our bodies are continually viewed as not okay due to misguided and racist notions of "what health should look like," especially in medical spaces.

Kae's Story

In an effort to heal herself, Kae had weight-loss surgery when she was 21 years old. She describes some of the reasons she decided on the procedure:

I feel like I had weight-loss surgery because it was something new that was coming out. I found out my dad's insurance covered it, and I thought it was a fix-it ticket. A lot of people that get weight-loss surgery see it as a fix-it ticket, but really, in all actuality, it's just a tool. It's not going to do it for you, but I felt like if I lost weight people would look at me differently, and they did.

Kae's feelings about why she decided to have weight-loss surgery demonstrate how complex body image can be and how body-image relates to both our inner feelings of self-worth and how we are perceived by others. Along with feeling it would be a "fix-it ticket," Kae admits she was also motivated by wanting attention from men. She was also motivated because she wanted attention from men, since her girlfriends had "boyfriends and stuff." However, now that she's had the surgery, Kae feels resentful because she now often feels objectified:

[After the surgery] I started becoming resentful so that made me even more angry. Sadly, I feel the way that I look attracts a lot of Black men. I felt objectified, and I felt disgusted. It made my relationship even worse with Black men because I'm beautiful, and I have a beautiful face, and now I have a skinnier body, and that's even more attractive to you, but why wasn't I attractive to you before? I feel like before I had weight-loss surgery I was desperate for love. All of my friends were having boyfriends and stuff, and I just felt like I needed to do it because everybody else was doing it. But then I realized how hard it was because I was the fat Black girl.

During her initial visit, the doctor offered a different surgery than what she wanted because, he said, "it was cheaper, and if your insurance fails, I won't lose that much money." Kae stated, "I feel like he was on defense mode because I was Black." Despite feeling this way, she continued on with the procedure and endured even worse humiliation just minutes before the surgery:

Before surgery, I'm getting my injection to fall asleep or whatever, and he's like, "Your stomach is still the size of a football, so if you decide to fail on this because you're not going to put in the work you're going to die." The anesthesiologist is next to him, and he was injecting me, and then the doctor left, and I started crying. Then the anesthesiologist is like, "Don't listen to him." He's like, "It's okay, everything's going to be fine." But I felt like, *Why do you feel so empowered to talk to me like that?* That's when my relationship changed with my doctors. Now I feel like I have to do my research before I go to the doctor and ask for something because I always receive pushback. I have taught myself to always have my head held high when I am in those types of spaces, or if I have to go to the courthouse for something, I think, *Make sure that your head is held high.* You are making very, very serious eye contact so that these people know not to fuck with you because you're not like all these other Black people that they're trying to put in them. That's hard, always having to be on the defense because you're going to be treated differently

It was interesting to see the dynamics of assumption of financial status and the mistrust of a Black patient being able to pay for requested services. In Chapter 2, I discuss physician bias; research suggests that "implicit bias may contribute to health care disparities by shaping physician behavior and producing differences in medical treatment along the lines of race, ethnicity, gender or other characteristics" (Chapman, Kaatz & Carnes, 2013, p.1504). Physician bias is evident in Kae's case; the doctor was trying to advocate for a cheaper option for surgery and took away her autonomy, prioritizing his own benefit based on the assumption that her insurance wasn't good. This experience made Kae stand up and fight for herself, a turning point for her and her future relationships and interactions with doctors. She also describes what she now sees as the importance of researching for a "good" doctor and her own health before asking a doctor. In the interview, Kae explains how to show up in that space as a Black body: "Head held high," "eye contact," "confidence." Navigating these crooked rooms, and always having to advocate for oneself, taking necessary extra steps for a doctor's visit (like doing your own pre-health

screening), can be exhausting mentally and takes its toll physically for Black women with chronic illnesses. There is a phrase called—“practicing defensive medicine”—which usually refers to clinicians who do a lot of tests so that they don’t get sued; they are preemptively “defending” themselves against a lawsuit by sometimes doing more tests than indicated. Here, I am describing a different kind of defensive medicine, a kind that Black women/patients feel like they have to engage in to receive minimally standard care.

In Chapter 3, specifically the Thick Methodology section, I detail the foundation of the work from Tressie McMillian Cottom’s work in *Thick; And Other Essays* (2019). She describes the need for Black women to always conform to society’s standards, similar to the way her own mother constantly told her to change the way she placed her feet: “Black women always have to ‘fix their feet’ to fit into social standards.” She goes on to describe how “fixing our feet” is an extreme maladaptation. As Kae shared her story with me, it was evident that her experience was like a series of her constantly having to “fix her feet” in society, especially when she disclosed her defensive practices of walking into medical and court spaces.

Casey’s story

Casey just recently received her PhD in chemistry and moved to a new city from where she attended graduate school. She is in the process of building her medical network in a new area, and in our interview, she recalled visiting her new primary-care doctor:

Long story short, they basically told me that I was morbidly obese, and I really took it personally. How I justified it in my mind is that you’re morbidly obese if your weight can impact your health to the point where you can die. If I needed to run away from something attacking me, and I had to run for like a mile, could I make it? I am not morbidly obese. They told me with my BMI I’m like 65; basically, I have 65% body fat or something, so pretty much they said we’re going to send you to a weight management specialist. They were suggesting that I go to

this doctor so I can get weight loss pills. This is a big pharma scam. My thoughts were something like, ‘You’re trying to push these weight loss pills that are probably not FDA approved, or something that shouldn’t be in my body that may counteract with the hormones in my body. I’ll go to the consultation to see what the person has to say, but I would probably be better off going to a doctor where they can take my blood, tell me my blood type, tell me what my metabolism is, and give me some directions on how I can change that. Then I would know these are my hormone levels; this is how my hormones are fluctuating throughout the month, so, therefore, if you eat during these times of the day or [are] eating these types of food during these increments during the day it will be best suited for the chemistry of your body.’ I told myself that I have a whole doctorate in chemistry; I have mastered the art of chemistry, in a sense. Why can I not master the chemistry of my own body? I don’t think a doctor could ever give me a unique plan built on general assumptions on women as a whole. I don’t think that is possible. I think certain doctors will push certain things for the financial kickback that they get; it’s not in the interest of me. I often feel unheard. I was so pissed; I felt down about myself. I always had a negative perception about my body image from the standpoint of weight and just being an everyday person. So how did I become obese overnight? It takes a mental toll; then you have to say, ‘Am I going to accept what the doctors say, or am I just going to try to do something on my own?’ Then that brings mistrust of medical professionals; then it’s like, ‘Who can I trust?’

Casey’s story begins with her doctor categorizing her as “morbidly obese,” a term she rejects based on her own feelings about how healthy she is. She is also very skeptical about the motivation of the doctor (she sees being sent to a weight-management specialist as part of a “big pharma” scam), particularly since the doctor did not ask her about any recent life changes that may have occurred. Although Casey has a PhD in chemistry, she admits the chemistry of her own body eludes her, in part because doctors are not willing to treat her as the unique person she is. She states, “I don’t think a doctor could ever give me a unique, [but instead, makes a plan that is] built on general assumptions on women as a whole.” She feels though she was automatically placed in the category of “morbidly obese,” as if she “had gotten there overnight” because she sees the medical establishment as not willing to go in depth about her reality, and not interested in her as a person, but rather as a customer. Casey’s story also highlights the distrust or skepticism

of Black patients (mentioning “big pharma scam” and “financial kickbacks”). Casey may have already been skeptical of medical establishments prior to this experience, but I think this encounter with this office either heightened her distrust or highlighted the medical establishment not seeing her as a human by not asking her certain things or doing certain tests, rather treating her as another patient to profit from.

Life-changing events affect anyone’s weight, and whether the scale goes up or down, these events are likely to have effects on the body. Casey had just finished a PhD in chemistry, found a job, graduated, and moved all within a month. Those are huge but stressful accomplishments that can take a toll on the body, and everyone’s body has a different reaction toward stress. In Chapter 1, specifically in the section “Racism, Stress, and Weight,” I discuss how stress affects weight and cravings for certain foods while the body is in stress mode. None of the surrounding issues that may have played a part in Casey’s weight gain were taken into consideration. In Chapter 2, in the sections “Black bodies as teaching tools” and “Physician Career Advancement,” I discuss Black exploitation within the medical space. Casey’s predisposition to feeling skeptical may have been due to this history of Black experimentation and exploitation.

Billy’s Story

Billy is a Black woman who felt her provider did not adequately address her pregnancy-related concerns. She had an abortion with her fourth pregnancy because her third delivery experience was so traumatizing.

Unlike her first two pregnancies, Billy experienced what she described as “fluid retention” and uncomfortably swollen legs after she delivered her baby; she also had headaches, both during and after the pregnancy, which were sometimes difficult to control. Concerned, she did some

research on her own and concluded that she might be suffering from a condition known as postpartum preeclampsia⁴. When she brought this to her doctor's attention, her doctor replied, "Yeah, I think you do too." This seeming lack of concern and attention to a condition that is associated with serious symptoms, including seizures, left Billy feeling neglected. The doctors were not helpful. She was gaining weight while she was pregnant, but the baby wasn't getting any bigger. She had had two pregnancies, so she knew what was normal for her body during pregnancy. With the third, she gained a significant amount of weight almost immediately, "which is a sign of preeclampsia," as she stated from doing her research. When she voiced her concerns, "[t]he doctors were talking to me like I was stupid." One of the things the doctor said to her was that she should work out and eat more vegetables. Billy, who grew up poor, had been slender as well as a vegetarian most of her life. During her interview, she spoke in-depth about growing up as a slender child into womanhood, not "filling out" her jeans and clothes, and her mother always having to tie and tailor her clothes. This is important to note because the doctor clearly did not care to read her history as a vegetarian or care to diagnose this weight gain as something that was very abnormal to her body.

Billy, who had delivered her first two children without pain medication, wanted to have her third child that way, too. She describes feeling as though she was the first woman in this hospital ever to have a natural childbirth because the staff didn't seem to know how to handle her birthing process. Throughout the entire birthing process, the doctors pressured her (and her

⁴ "Postpartum preeclampsia is a rare condition that occurs when you have high blood pressure and excess protein in your urine soon after childbirth. Preeclampsia is a similar condition that develops during pregnancy and typically resolves with the birth of the baby. Most cases of postpartum preeclampsia develop within 48 hours of childbirth. But postpartum preeclampsia sometimes develops up to six weeks or later after childbirth. This is known as late postpartum preeclampsia. Postpartum preeclampsia requires prompt treatment. Left untreated, postpartum preeclampsia can cause seizures and other serious complications." (Mayoclinic.org, 1998-2022)

husband) to consent to a C-section. When Billy was going into labor, the doctor came in with her street clothes on, which from the beginning made Billy feel as though the doctor was not prepared for her labor. While in labor, the doctor required Billy to stay in the bed, even though during the beginning stages of labor, women are often encouraged to get comfortable and move around. With Billy's other children (delivered with a different provider), she had been encouraged to move during her labors and found the best position for her was to deliver while standing.

Billy eventually gave birth without the doctor's assistance. In fact, the doctor was on the other side of the room, looking at her phone. After the baby was born, Billy could tell that something was wrong. The placenta was very big, and the baby was only five pounds. Billy got out of bed and walked over to see her baby, who had been placed in a bassinet, and she describes the medical staff being surprised, like "Oh, you're up?" Billy says, "I was like, I had a natural childbirth. I can move." During the interview Billy reflects on her experience and the impact it had on her afterward, particularly during her fourth pregnancy:

All of the ways that they couldn't listen to me, that I know what my body is doing. Also, I am a researcher, so those two things ... I just felt like everyone should be listening to women about their bod[ies]. Also, I can read and understand, and I am asking you questions; you don't have to talk to me as someone who doesn't understand. Don't talk to me like I don't have a brain in my head, and that is how it was the entire time, so much so that [when] we got pregnant with the fourth, I was like, 'I can't do this again. I can't, I just can't.' What doctor was I going to find here in Indiana that treats people with some sense? It was just very, very scary; very, very scary. We ended up having an abortion because I couldn't. I just couldn't wrap my brain around it. I know you shouldn't make decisions out of fear; I was just so scared.

After Billy shared her personal and traumatic experience engaging with CRoM, I couldn't ask her anymore questions. I couldn't morally/ethically continue to pull from her and cause her to relive the pain she experienced, which is an example of Black feminist research ethics. It was

difficult to get all of the details from her interview because I made this decision to not further traumatize her, which is also apart of Black feminist research praxis of care and Christina Sharpe's (2016) methodology of wake work, "to care," as Black feminist research ethics. When I mailed her self-care box I put some extra love inside for her. I know from my own experience as a Black woman there are so many layers just to be and experience the natural and normal process of delivering a baby. Black women in particular have to think about their geographic locality and what resources are available. They have to wonder, "Am I going to be heard if something goes wrong?" *During my own pregnancy, I made so many abortion appointments because I was also scared to deliver my baby in Southwest Virginia; I just didn't have the nerve to show up to any of the appointments.*

Billy's story demonstrates how Black women are not listened to and even infantilized. No one through the process of her birthing her third child would listen to her recent previous birthing experiences or even her health history. The doctor oftentimes did not believe her about her concern of having preeclampsia. It did not matter that she is an educated Black woman with a PhD; the medical staff treated her like she was incompetent. They also kept important information from her, when she had postpartum preeclampsia; she had to figure it out on her own. That is dangerous for her and the baby. The sum of these experiences with the CRoM added up to the point where she couldn't face having another baby. In Chapter 1, in section "Intersectionality and the Crooked Room of Medicine," I discuss maternal mortality rates (and racial disparities), suggesting that traumatizing births are extra scary for Black women because many of us are aware of these alarming rates. Not being heard or believed while in a medical space as a pregnant Black woman in contemporary times feels like you are in a Jordan Peele horror movie.

Elizabeth's story

Elizabeth, a thin Black woman, reports that she almost died while being a surrogate. Just like Billy, Elizabeth describes the ways in which throughout her birthing process she was unable to advocate for herself. In our interview, Elizabeth describes her near-death experience, where after she had given birth she was not informed that her placenta hadn't come out. She recalled "bleeding out" for about 30 minutes post-delivery and that when a nurse tried to advocate for her, the nurse was dismissed by the doctor. Elizabeth shared that she felt like she was just a check on the doctors to-do list. What is particularly heartbreaking about her story is that Elizabeth actually did her research and communicated her needs prior to her delivery. She shared that her doctor throughout the pregnancy was amazing; however, when she was ready to deliver it was during the holidays and her doctor was out of town.

It was more about [the doctor's] role as a professional and things to get done off her list, and I just happened to be one of the tick marks on her list, so that baby coming out of me was just a check off her to-do list. She didn't see me as an individual or hear my voice, and I suppressed my voice as I had done in the past so that I could get through it and get to the other side of it, but at some point I had to speak up because I was going to lose my life.

Elizabeth shares how she has suppressed her voice in the past and how she was even ready to continue to suppress her voice in this experience to get to the other side. However, she knew that she had to speak up or not making that decision was going to be extremely detrimental to her. Not only did she find power in speaking up; speaking up saved her life. Elizabeth describes her birthing experience:

After the baby had been delivered, there were a few times where I just felt like [the doctor] was stuffing a turkey. She would go in to check my cervix, and there was no gentleness involved. Sometimes she wouldn't speak when she did it. She just

came and just did what she was going to do. It was just very disheartening. It just takes you [a]back too. It really felt like I was just being a producer.

After the child was delivered and [the doctor] had no concern about my pain, there was a time where [the doctor] was just silent, just sitting there, and I could observe and see that there was an issue, so I asked about it, and come to find out my placenta didn't detach from the uterine wall. She had been sitting there waiting for it and tugging, and it wasn't happening, so she was just thinking through the process instead of communicating with me. She mentioned that she was going to have to take me to the OR to remove the placenta manually by reaching into my uterus and pulling it out or cutting it out, and I was like, "Okay," but meanwhile, when she was mentioning all of that, she forgot to clamp the umbilical cord, so I had been bleeding out for the entire 30 minutes that she was sitting there and really trying to figure out how to save her checklist, is what it felt like.

Elizabeth's story highlights the impersonal nature of the CroM when she was treated like a "producer" rather than a real, living, breathing, and *bleeding* person. As discussed in Chapter 2 of this study under the subheading Black bodies as teaching tools and Physician Career Advancement, I discuss the legacy of the mythology of Black bodies as able to tolerate pain more than others. Elizabeth's story is but one example of how this legacy continues to impact Black women. In the crooked room of medicine, Black women's pain is minimized or sometimes not acknowledged at all. The doctor attending to her delivery did not even feel like it was important to talk to her during her medical procedure which ultimately took away her agency. She was treated as just a vehicle to birthing a baby, and her own life wasn't seen as valuable.

In Chapter 2, under the section of "Power Dynamics," I discuss interactions between patients and doctors, physician decision-making, and provider-patient dynamics. Studies show a persistent gap between Black Americans and white doctors. Cooper-Patrick et al. (1999, p. 583) note, "Generally, Black Americans feel that they participate less in their interactions and decision-making with physicians than white Americans, but not when their physician is of the same race/ethnic background." Although the nurse was trying to advocate for Elizebeth, she too was

dismissed and shut down by the doctor. It was disheartening that Elizabeth received this type of neglect. Her story highlights the real impact of physician bias, mistrust, misdiagnosis, and mistreatment, as well as Black women's internal debate when attempting to speak up and out against these impacts, also tying to Kae's story and using the concept of "defensive medicine" for Black patients. Fortunately for Elizabeth, she chose to assert her agency and power and speak up. It was unfortunate that it had to be in the face of a life-or-death situation. Elizabeth's story also highlights that regardless of weight and size, Black women will endure traumatic experiences in CRoM.

Elizabeth's story also mirrors situations and experiences that I lay out in Chapter 1. In the section entitled "Intersectionality and the Crooked Room of Medicine," I discuss Khiara Bridges' 2011 and Dana Ain-Davis' 2019 works on how the intersection of race, gender, and class can have powerful consequences on how Black women experience maternity. I also discuss how Elizabeth's experience is linked to Saidiya Hartman's 2007 theorizing of afterlife of slavery. Hartman writes, "Slavery had established a measure of man and a ranking of life and worth that has yet to be undone" (p. 6). Hartman's theorizing shows clearly in Elizabeth's story; the doctor missed so many steps that were completely life-threatening to her.

The stories detailing Diane, Kae, Casey, Billy and Elizabeth's similar and different experiences with the CRoM demonstrate and highlight that crookedness, each experience very much different but with historical, social, and medical discriminative undertones that played into their experiences. For many of these women, outside of their partners, I was the first person who they shared these stories with in a while, which was evident in their tears and eagerness to talk with me. These women's stories are not documented using Sharpe's (2016) methodology of the

process of annotation and redaction. I am bringing these stories to light and focusing on the human narratives from the CROM. I interviewed 12 women but chose these five as they are representative of the major themes of this project using the Black Feminist Methodology of Sharpe's annotation and redaction, breathing life into women's stories that may have been ignored if this project did not call attention to such experiences.

Double-Edged Sword of Black Women Advocating for Ourselves

For Black women, advocating for yourself can be a double-edged sword; you don't want to be labeled as an "angry Black woman," but it is also important to speak up for yourself, to not be a pushover, especially when it comes to your health and your body. Speaking up can be very uncomfortable and difficult. As Kae stated, "It's hard to always have to be on the defense when you're treated differently." Diane, the woman who shared the story about wanting her IUD removed, describes her uncomfortable feelings when her husband advocated for her after talking to her about her appointment:

Then I called my husband. He's, like, spazzing out. He calls them and he's like, "This is malpractice. How are you a woman's doctor and you're not sensitive to a woman's mental [health]?" They called and they apologized and everything, but now the overthinker in me is like, "Now there's some kind of note in my file." I go to a visit after that, two years or whatever, and I'm smaller. I feel like they are tiptoeing when talking to me, so it makes me uncomfortable. It's crazy because I had an appointment there this past February, and I couldn't go. I don't want to change my doctor because I like my doctor, but I had this fear of everybody looking at me and still seeing the same person. It's crazy, but I have never felt that way until then.

Diane is a YouTube fitness instructor and has been very transparent about her weight-loss journey online. She has lost a significant amount of weight. However, even having lost weight, feelings of not being good enough and having to always prove herself have never gone away.

When you stand up and advocate for yourself, particularly if it is not the “proper way” — with raw, human emotions — there is another layer of difference, especially for Black women when we may feel like we have been labeled a “problematic patient.”

I witnessed this with my mother’s oncologist in October. My mother is very outspoken and straightforward. Because of her race and body size, she is quickly pathologized and labeled as “aggressive,” especially when advocating for herself in medical settings. She is a cancer survivor, and in 2021, her cancer came back. When she advocated for herself, she was then labeled an “angry black woman” and was asked to find a new doctor.

After my mother had to remind the administrative assistant at the doctor’s office that she is a cancer patient, the admin called my mother aggressive and told her that she felt like she was being “attacked.”

Here’s the full backstory. My mother had surgery to have stage-one cancer cells removed. After the surgery, the incision kept filling with liquid. She had to keep going back to get it drained. By the third visit, the surgical doctor had her wear a plastic device that hung from the incision for a week. During that time the incision became infected and half of my mother’s body was infected, swollen, and red. The facility that performed the procedure told her that she had to go to an infectious disease doctor, and they could no longer help her. After the administrative assistant gave my mother this information, she then called my mother aggressive and said she felt “attacked” because my mother voiced her displeasure that she was just given an address for the infectious disease doctor. No assistance with referral, no apology, nothing.

I had to call the office myself and tell them the harm such labels can do to patients who are unheard. I frustratingly told them that they needed some cultural competency training when dealing with patients. I asked how it had gotten this far, saying, “Anyone knows that if something

is hanging from a fresh surgical incision, it is going to get infected.” The medical institution where my mother went for her cancer care is supposed to be the top cancer treatment center in California. After that, the doctor no longer wanted to work with her, and told her she may do better under the care of Community Memorial, which is not the best possible hospital for people of color; patients often complain about not being heard.

A person fighting cancer and their family should not have to deal with such traumatizing experiences back-to-back. No one should have to plead a case for getting proper cancer treatment and endure what happens when they fight back. I am not sure how to begin healing without being able to advocate for yourself.

Another strong theme in this analysis is the extra labor that Black women/patients have to do just to receive appropriate health care. As mentioned in Kae’s story, it is common for patients to practice defensive medicine, an almost “prescreening.”

After the CRoM Experiences

Though I purposefully did not ask my participants specific questions regarding healing within the matrix interview guide, I wanted to see if/how organically they broached the topic of healing within our conversations⁵. Because everyone may not be in the process of healing or may not fully understand the concept of healing, I did not want to push this concept on the first-phase interviewees. As a researcher, I became interested in how the women I interviewed coped with some of the experiences they shared. Many of the women spoke freely about topics such as positive body image discussions in the household and conversations about healthy foods with their families; advocating for themselves/speaking up; and experiencing healing through self-care,

⁵ The continuation of this project will ask specific questions on healing that will be added to the GRW matrix

putting themselves first, and reclaiming and redefining their identities through success in their careers and/or personal lives. They keep showing up for themselves, their families and communities; they are still living their truths and being great and amazing women, regardless of their past traumas and experiences in society's crooked rooms. In the 2018 book *Black Women's Liberatory Pedagogies*, Jennifer L. Richardson argues that "a part of healing must involve Black women's power to reclaim and redefine their identities" (p. 284).

In all of these stories, it became apparent that healing was not a one-step process, but rather an ongoing series of actions of Black women finding their own powers within the crooked rooms we must live in. Richardson (2018) describes the large collection of literature that indexes the record of damaging historical and contemporary depictions of Black women (Akbar, 1984; Collins, 1989; Downing & Husband, 2005; Hall, 1997; hooks, 1992; Richardson-Stovall, 2012). Black women live under constant false and deficit images and narratives of Black womanhood. To heal from this past, Richardson writes, "Africana women, who have been historically disenfranchised, colonized, objectified, and had their identities violently constructed, must turn to the business of healing, self-recovery, and wholeness" (p. 282). Richardson defines healing as "an act of resistance to oppression that can produce counter knowledge, celebrate the spirit, and foster community through affirmation and sharing, particularly as it pertains to Africana women" (p. 282). She continues to affirm, "When [she] invoke(s) the term 'healing,' [she] seek(s) a continuation of Audre Lorde's (1976, 1984) work, which locates healing at the center of our interactions not just with ourselves, but also with our students, co-investigators/subjects, colleagues, and others" (p. 282). What is also apparent in this sample of women was how they keep showing up in the world, regardless of their traumatic experiences navigating the crooked rooms in society.

For example, Elizabeth is a shamanic healer and transformational life coach. She shares:

While answering the call to be a gestational carrier, commonly referred to as surrogate, I accepted the mission to create nontoxic all-natural candles with healing crystals. I was learning more about my body than ever before. I made a powerful decision to consciously choose the energy I wanted to absorb and get rid of the energy polluting my senses. Soon I was reminded of how truly magical I am. How magical every soul is! Distractions of the senses, of the mind, and of the connections within the body interfere with our natural abilities to heal, consciously manifest, and follow our soul's journey with ease. In my practices, I've regained access to spiritual gifts that aid me in guiding others to tune into the truth of who they are.

Elizabeth found healing by living her truth. "I feel healing happens by default, as I serve in showing others how to live a connected, empowered life."

By living her truth, being who she naturally is, and not letting anyone or any experience define her, Elizabeth shares this knowledge and this receptive way of living, which in turn heals her while healing others; this is Black feminist praxis.

Ashley is another woman I interviewed; she is a registered dietitian and the director of a university dietetics program.

Dietetics is a very white field; there are not a lot of people of color in general within this discipline. I can also attest to this because in efforts to "fix" myself, I went into the field of nutrition and dietetics and received my Bachelor's degree. Even though I went to an HBCU, I was one of four Black students within the department. I did not continue in the field because I did not see myself; I did not see anyone in the field that looked like me. It was uncomfortable for me not just in the academic space, but also in the actual field. My HBCU had an amazing RD internship program, but all the women that came into that program were white. I also wanted to

help my community, and I knew my community needed something more than BMI charts and conversations about fruits and vegetables. I knew there were deeper issues.

Ashley explains her struggles as a thick Black woman who is a registered dietitian.

Just even in our dietetic space, the people do not believe that I'm the director. It's always, "Oh, you're the director?" I get it from the colleagues and the students, the white students that are trying to get into the program. It just gets to be, yeah...

She also discusses how her personal life collides with her being an RD. She describes the difficulty of talking about weight all the time or being held to an unrealistic standard.

We're constantly talking about food and body image. I think partly because I am a registered dietitian and teach nutrition, even if I don't want to talk about it, somebody's bringing it up. It's a constant conversation, whether they're judging me for not holding up to my standards. So you shouldn't eat bad, or you shouldn't be having these issues, or are you going to say anything to them? I just want to hide, just leave me alone. Can we just be normal for once and not have to think about it? And then, of course, my daughter and son see my struggle with trying to lose weight, and they are aware of some of the chronic diseases I've picked up over time. They know I'm in Weight Watchers. It's a constant conversation.

Ashley has achieved amazing accomplishments as a Black woman in this field. She succeeds and continues to show up (and shows up well) through her constant vigilance. She has been able to succeed in spaces that are hostile, where showing up is a revolutionary act. Ashley continues to claim her identity as a thick Black woman in dietetics.

Healing yourself, putting yourself first in efforts to change your community is central to Black feminist work and praxis (Lorde, 1974, 1984; Taylor, 2018; Richardson, 2018). Richardson also argues that "a part of healing must involve Black women's power to reclaim and redefine their identities" (p. 284). Though I did not ask specific questions on healing, I know that the work that goes into healing is never done; it is an ongoing process.

Billy, one of my interviewees, found empowerment by changing her location and also locking her hair. She stated, “[After] locking my hair...I feel beautiful, I feel confident, it’s freedom. I feel liberated; I feel so much better about *me*, with my hair like this.” Billy’s descriptions of her experiences echo Black feminist research that addresses healing through affirmations of Black women’s hair and loving our bodies (Griffin, 1996; Johnson & Bankhead, 2014; Tate, 2016; Eley, 2017). Billy’s success and imprint in her career shows how she reclaims, identifies, and thrives through her CRoM experiences and navigating crooked rooms. She has a great amount of accomplishments in and outside her field of study; she has written books, been a publishing supervisor for various journals, the list goes on. Billy ends the interview with beautiful encouraging words:

But I guess I’ll probably end with just feeling a big sense of gratefulness and being blessed that my life is not how it started out. I was talking to you in the beginning about how poverty shaped, I think, all the answers to your questions in the beginning. That now because of favor, having my mama, doing what she could do to set us up to what we are doing now, it’s just a blessing, doing a sacrifice to get the Ph.D., not making no money. But now I got some money. I got a career, I got tenure. All these things have paid off in the long run. I think the takeaway, or the thing I want people that come away from your work [is] this isn’t endemic of Black womanhood. No, this is structures of racism, this is structures of sexism, this is structures of capitalism that have made Black women’s lives look like this. It is not because we are inherently unequal, unworthy. These are the structures that have done damage to us. I want that to be a focus because life looks so different for me now than it did when I was growing up. That is because I’m not living in poverty. That’s it. I’m blessed. I’m not saying I did this on my own. I’m not giving that story at all. I ain’t one of those [who say], “I pulled myself out of bootstraps.” No, it takes a whole community. That’s why I’m honest with you so that you can get your dissertation done, because it takes a community. It’s all of that. If we don’t really address...these generational traumas, the generational curse of poverty, of not really sitting with where we came from because it doesn’t have to be where we end up...this is a problem. I’m here for this work.

What I remember most about Billy’s interview aside from her experience with CRoM is how she heavily discussed growing up in poverty and how that affected her as a young Black girl.

However, despite that Billy continues to re-imaging and reclaim her identity and even encourages me to do the same.

Michelle is another woman that I interviewed. Michelle's traumatic experiences were centered within the crooked rooms of academia and the crooked room of mental health. For Michelle, she hopes to heal her community by healing herself first. She also mentions finding healing through taking care of herself first, and teaching her children to care for themselves first as well. Michelle speaks about the importance of being aware of your own self-care:

I hope, through the work I do in healing myself and healing my family, I hope to heal my community. And I hope that when I grow older, and when my children see me, they're like, *Yeah, my mother, she did her part*. But one thing they could say about me is that I took care of myself first because that's what I want to instill in my children, *You can't save nobody until you save yourself*. Everybody wants to be a martyr and a leader, but how does that look when you can't even do that for yourself?

Healing, inner work, self-love and self-care has been centered in Black feminist praxis, work and music. Lauryn Hill's 1995 Doo-Wop (That Thing) when she repeats 3 times "*How you gon win if you aint right within*" references the inner work one must do to truly "win." Radical acts of love, self-care and loving Black love has been the theme of Black feminist conversations on healing, specifically healing from systemic oppression (Sonya Renee Taylor 2018; bell hooks 2001); Audre Lorde (1976, 1984); Alicia Garza (2014); Angelique Nixon 2020; Trichia Hersey (2018).

Although all of these women had different stories to tell, they each expressed the importance of caring for themselves. These findings add how Black women reclaim and redefine their identities through their work, career, degrees and/or through everyday practices. Based on

this pilot data, I suspect that you never come out of society's crooked rooms so Black women have to figure out a way to just be...be happy...be whole...be healthy.

Healing Practice and Black Women's Health

Crystal healing, reiki energy healing, visualization divine mirror, skin, self-care, self love affirmations, natural walks, social media groups that affirm me, Bible verses, African and Egyptian spiritual texts, therapy, Welbutrin and lots and lots of prayers, crying and begging... This was the intention as I embarked on my own journey of healing.

Bettina Judd 2014, *Patient*
Fill A Woman with Meaning

Look
uninhibited.
Children
the stroll
no lye relaxer

Tell her
how to
rest her chin
wipe her tears

when to
become woman
make love
never forget.

Explain to her
her sadness
fibroids,
miscarriage
blood sugar,
Welbutrin

Bend a spoon

find the torn,
the growing,
Find what separates
apes from men.

In chapter 2, under *The Impact* section, I discuss healing and stated “Crooked rooms can impact Black women in various ways, and literature often reflects a healing process from such pain, anger, and hurt”. Also in chapter 3, in *Healing not fixin’ feet* section, I discuss how this project is about Black women healing holistically and not about Black women having to “fix their feet” to fit into categories of health. As a reminder I mention Evans, Bell & Burton’s 2017 book, *Black Women's Mental health: Balancing Strength and Vulnerability*, and how they define health with healing in association to Black women’s health:

The term healing is purposefully chosen as a component of the model because “health” cannot occur without it. Health is not something one has or does not have; it is a constantly evolving process. Black women are in a perpetual state of healing from specific experiences of trauma such as abuse and degradation as well as from global experiences of racism, sexism and economic disenfranchisement. (p. 6)

Therefore this concept of healing is most important to Black women’s health rather than pointing out flaws, encouraging Black women to continue “fix their feet”, or even basing health from a flawed paradox. Real health and healing is centered in and comes from love and care especially for oneself as is. In chapter 2, under *The Impact* section, I discuss Thompson’s (1995) work, she defines Holistic healing, which I argue and encourage for Black women’s health:

A holistic healing process —involving the mind, body, and spirit— draws on innovative and creative strategies. The healing methods developed by the women I interviewed reflect tenacity and a willingness to recreate what was injured or destroyed by trauma. Healing mirrored —was the reverse of— the trauma, a discovery of aspects of themselves long lost or hidden from view (p.107)

Black feminist politics and praxis is centered in radical Black love and self-love and self-care (Taylor 2018, hooks 1999; Barlow 2016). This love “is to have a space where Black women can find healing in others’ moments of clarity about self-love, self-care, mental health, and well-being” (Barlow 2016: 205). Black feminist Venus Evans Winter’s (2020) work centers in changing narratives of Black people in the Diaspora as forms of healing. In her webinar, *How does Dr. Venus Evans-Winters change the narrative about how Black folk thrive during a pandemic?*, she states, “Molefi Asanti defines Afrocentricity as the study of the ideas and events from the standpoint of africans as key players rather than victims this definition is very important... that's what i meant by we're going to shift the narrative or change the narrative around what is a pandemic so we're not starting with black victimhood or black people as the victims”. In addition, Tamara Winfery-Harris’ 2015 book, *The Sisters Are Alright: Changing the Broken Narrative of Black Women in America*, is focused on changing narratives of Black women and girls specifically as a channel of healing. Changing and pushing back on narratives is also another form of healing, as so much harm has been done due to false ones.

Black Feminisms and Healing: My Healing Story, Where Crooked Rooms Collide

Mikki Kendall’s book *Hood Feminism* (2020) makes a point to include all women in the engagement of feminist work in all class struggles. *Hood Feminism* is about not leaving any women out, including low income women-- women from the neighborhood that mainstream feminism has often left out. It’s about thickening the academic fields of Women and Gender Studies and Africana Studies. It is about the inclusion of women who live in the projects and women living below the poverty line, and centers on the healing and inclusion of all women’s experiences, from gun violence to housing. I believe this extends to women in the system/struggle of mass incarceration as well, and the exploitation of this system.

I mention mass incarceration because my partner was incarcerated the week before our daughter was born on a “probation violation” for something he did over 12 years ago and has already done the time for. Originally, I was embarrassed about the stereotypical situation I was in as a graduate student at a research one institution...*How did this happen to someone like me? Similar to Diane’s reaction, I was thinking “here I go again...proving that I don’t belong...feeling like an outsider...my partner being incarcerated was a blow to my self-esteem as this graduate student...Food quickly became used as my escapism. I found myself relying on what I have always counted on to relieve stress, which is eating.*

Mass incarceration has “disproportionately affected low-income and minority populations” (The Sentencing Project 2010). With 2.2 million people incarcerated, the US has the highest incarceration rate of any country in the world, with more than 60% coming from “minority” communities (The Sentencing Project 2010). People who enter the criminal justice system are overwhelmingly indigent (Alexander 2012; Sentencing Project 2010). Two-thirds detained in jails report annual incomes under \$12,000 prior to arrest (Alexander 2012). People in this system who make a lower income have to pay so much money just to speak to their loved ones, and the pandemic made it even worse. Free visits turned into charge by the minute video calls. The penal system is terrible, and exploits the poor and mentally ill even further; *unfortunately, I am experiencing this first-hand. Here I was a full time Phd student, living in affordable housing, on TANF (no welfare or food stamps), straddling the two fences of (race and) class. I was 5,000 dollars in credit card debt on calls and food the first year my partner was incarcerated while having a newborn baby during a pandemic...I thought, this is ridiculous and makes no sense! I never felt more exploited, uncared for and unvalued while dealing with all these multiple oppressive systems. I spent my time writing letters and calling public defenders,*

lawyers, coalition for justice organizations, and searching for someone, anyone, to help us. He was facing nine years and the court appointed lawyers made sure I got that in my brain. Just like Diane's provider made sure to get it in her brain that she was too "big" to reproduce in her CRoM experience. The crooked room of justice was eating me alive in all angles. As I navigated social services, courts, even WIC and being stereotyped even further in this area, I quickly became drained and beyond depressed while having to write complaints about my interactions with these services while trying to advocate for myself, my child, and my partner in all dimensions of life. I was dealing with the crooked room of justice, the crooked room of academia, the crooked room of U.S Human services and CRoM all at one time.

I mention this as an example of how crooked rooms collide, also discussed in Chapter 2. Crooked rooms affect the physical body, mental health and even the spirit, and my spirit was crushed. I was standing between intersections of serious class issues while not being seen, heard and depreciated as a Black woman in the academy (Benjamin 1997; Davis 2004; Robinson 2013; Allen & Joseph 2018; Baldwin 2021), and then not being seen, heard or valued outside of the academy when dealing with social services courts and housing- on top of dealing with my own mental health issues that I had before and after the baby, and trying to navigate institutions with a learning disability. It just felt like systems and systems of suffocation. It felt like trains crashing into my body all at one time, lightning bolts hitting from every direction. While reading **Hood Feminism**, I felt included, seen, and had some hope to find healing. I thought, Even though I am not from the hood, I am dealing with some hoodish stereotypical shit. Reading **Hood Feminism** — and finally reading something that saw me and my hardship — was helpful, but I still didn't know what to do next. This threw me into a dark deep hole of depression tied with postpartum depression and anxiety, as well as issues in the academy that made me feel like I was standing in

the middle of a sea of people screaming to the top of my lungs and no one would look my way. Going to sleep at night and waking up to my reality from dreams of being reconnected with my daughter's father was the worst part. Joyce Arditti, self-proclaimed *Prison Widow*, described in her 2002 article, *Doing family research at the jail*. It resonated with me deeply:

Here is what it is like to be a prison widow: it is like going to a funeral that no one attends..This is my research tale. My pain, transmuted by scholarship....I still dream of him- usually I am attempting to visit him or trying to get him out. Once I dreamt I was actually locked up with him inside the jail and we were both chained to the bunk bed. Sometimes in my dreams we are free. Once I dreamed he, I and our daughter were swimming in a beautiful turquoise-blue lake. But he is always gone when I awake and I am alone...I wonder if the research is a way to keep him close-a way to make him real out here (3).

For me, the research and even writing this and getting these deep feelings and difficult moments out of my body, transferring it on paper to hopefully help others, is my healing process. Waking up to this reality is more painful than pain itself. The dreams are even more painful...knowing it's just a dream and not reality...even knowing it's a dream while in the dream....never wanting to wake up...feeling stuck and broken, so broken and uncared for in all spaces and dynamics of life in and outside of institutions systems and policies, feeling lost, like no one cares ..feeling alone...screaming and ...no one cares..no one cares...no one cares...Having someone you care about, facing nine years, for a non-violent probation violation, felt like a hell I couldn't escape from...I asked myself, what antebellum movie did I fall into...

Ay yo I'm slippin' I'm fallin' I can't get up
Ay yo I'm slippin' I'm fallin' I can't get up
Ay yo I'm slippin' I'm fallin' I gots to get up
Get me back on my feet so I can tear shit up
-Slippin, DMX (1998)

This is the reality of dealing with oppressive systems all at one time — the definition of intersectionality and navigating Black womanhood in the U.S. This is also an example of my discussion in Chapter 1, Patricia Hill Collins’ 1990 matrix of domination theory and the discussion of interlocking systems of oppression in terms of race, gender, class and other categories. This is the first time I may have wanted to die, not suicidal or a physical death, but to be somewhere else; a different reality to disappear somehow...escape ...all I wanted to do and all I did was cry...and eat...As usual, the only form of comfort and escape I had from this reality was food. Food became my only form of comfort, and throwing all that guilt up seemed to be the only form of control I had in my life. Food became the only way for me to escape this devastatingly heartbreaking reality... I knew had to find healing...I had to find something...I continued to ask, *How did I get here?...I'm a good person.*

Media and shows like “Love After Lock Up” poke fun at people and women in these situations, not realizing that these are people who are still trying to parent, love, just be while incarcerated. There are 2.2 million people currently enduring the harsh conditions of incarceration. What about the mothers, single parents, sisters, and daughters outside, left to support their family on an already low income? *The crooked rooms of justice and CRoM have been colliding in the provision of substandard medical care for incarcerated people, with Covid-19 as the most recent and most deadly example.*

Black feminisms, Food, and Divine Healing

Participants in this study also revealed how they used food, binge eating, and excessive or binge exercising as means to cope with stress when crooked rooms collide. Diane, Ashley, Akua, and Candice all discussed forms of binge eating and binge exercising to maintain their body image during times of stress. As a reminder, in chapter 2 in *The Impact* section, I discuss Becky

Thompson's 1995 book *Hunger so Wide and so Deep: A Multiracial View of Women's Eating Problems*, I state that Thompson's (1995) work "challenges the social image of eating disorders and posits that eating disorders are a combination of survival strategies; a symptom of crooked rooms; and a response to the crooked rooms, particularly when you are looking at Black women".

Diane describes her own history with excessive working out, and how deceptive that disorder can be because people don't see it as a problem:

Before you continue, let me add something else because people don't think this can be an issue. People think working out can't be an excessive thing. Anything that you're doing excessively from a bad place is detrimental. I was overworking out in college to make up for how I was eating and stuff, so I became addicted to that. There's a point in my high school and in my college where I was a little bit bigger than what I am now, but it was because I was obsessing over fitness, [in a cycle of working out and binging] all the time.

Ashely explains how she deals with being a thick Black woman is a high stress job, and describes how she dealt with that stress in college was by eating:

[College] was like my first exposure to how to deal with stress on my own because my parents weren't there, and . . . I would have these foods and I would just indulge in them, and it was just helping me cope and feel better. Then move on to graduate school. I will go through the same period. It's like either I will go through periods of not eating but then it's like, okay, I have to get my fix. So I need that pizza, that Skittles, the Starburst, the honey buns and then transitioning, going through the doctorate and even now as a professional, I still want or go through those things since I'm having a hard time. We're trying to manage my health because I'm in a high-stress job, so it's like everyday, you know. We are trying to redirect, and we channeled that. . . Then I've seen where people have dealt with [stress], with food, and that is my current situation right now. Dealing with it with food.

Ashely also describes how her childhood "high achiever complex" effects her current professional life, and how she learned to cope with this stress with food:

I guess this high achiever complex or this pressure to excel and be perfect in everything, that has definitely traveled from my childhood and is in my professional life, I can't get away from it. No matter what people say, like you don't have to do that or you don't have to be perfect in everything, you don't have to juggle everything or be in for everything, I just felt I have to because it's like, this is my job, it's what I'm expected to do and I have to do it well at all costs. I think that pressure to excel, then it stresses me out, I put this pressure on me and then it's like, oh my gosh, I can't cope. I need my honey buns, I need my pizza, that's all I need right now. Then I'm just like, I'll make myself sick. I go through periods of cleansing and I adapt to this, but then I'll have a meltdown and then I'll put all this stuff in my body and then I'll feel sick because I've just ate all this stuff.

Akua, another interviewee, describes experiencing body image issues throughout her life, and the lingering effects from these experiences:

Because I was tall because [and] I was dark. All these things people would be like, they started sending these messages like you should be a boy or you act like a boy. It was this constant masculinizing. I was always struggling with my body because I was usually the tallest girl, the biggest girl. I have very distinctly West African features. Even to this day, I have a very indifferent relationship with my body because it's been so subject to ridicule. Then it wasn't even like I saw too many bodies like mine on a TV, or anything like that really. If I did, it was an older woman's body and so there are things attached to that, or if it was a body like mine, it's comedy. A comic relief or a comedic presence on TV, like Monique or her daughter, Kim. I just had a really hard time with my relationship with my body. I often wish I had a body that was smaller and that it was an hourglass shape, a more acceptable shape within the community.

Akua then explains her excessive working out habits, which were encouraged by the people around her:

When I was at my thinnest and I got the most compliments and the most love, I was not eating, and I was in a gym twice a day, and all the affirmations, all the compliments like, "Oh, you look so good." Then there was a point where I was just craving that, because I had never received that positive affirmation for my body. I was just working out like crazy to keep it.

Candice, who has struggled with weight since high school, also shared her excessive binge eating with sugar:

I decided not to do sugar in the year 2022, because that's my thing, like it's bad. December 25th I got a box of those sundae ice cream cones or whatever it's called from Nestle, the Drumsticks. I was like can I finish a 6 pack in a day, then I was like, Candice you are probably going to end up sick. I ate three on the 30th, one on the 31st, then I was like, this is problematic...So then January 1, I said, *No sugar*, so I did good January, did good in February, so then I go to a bridal shower with my friend and I end up having those little mini cupcakes, and I was like daaaaang...one turned into two, three, four, maybe five...you don't realize how much of an addiction you have until you're working hard to find alternatives. I dream about eating sugar. I dreamed I was eating a big cake in the month of February, and I woke up feeling so guilty...I didn't realize how much of a struggle it was, like I often go into CVS and get a Reese's cup... I want to work hard at fighting this sugar addiction because my mom has high blood pressure, and I don't want high blood pressure. . . . I don't want to be developing diabetes because I don't have control of my sugar intake. . . . That part has been a journey for me for sure, because I love sugar. I love chocolate, I love cake, dessert...I love the richness.

Candice's feelings of guilt with her sugar addiction confession was an intense and complex mix of feelings that she is describing.; managing her own bingeing while worrying about the racialized health disparities of diagnoses like high blood pressure and/or diabetes. In Chapter 1, *Black feminisms and "fatness"*, I discuss Sabrina Strings (2020) Op-Ed about how obesity became a scare tactic with Covid. *I too have a sugar addiction, which was something that I disclosed to Candice as a 'undressed' research tactic I did throughout my interview sharing pieces of me throughout the interview. I know for me when I was bulimic the purging would happen due to the overwhelming thoughts that Candice conveyed with the racialized health disparities of diabetes, high blood pressure and "obesity" scare tactics.*

Theologian, activist, and Black feminist Christena Cleveland, in her 2022 book entitled *God is a Black Woman*, is also transparent about her compulsive eating, bingeing, bulimia and use

of excessive exercise to try to exert control over her body; she later realizes many of her feelings concerning her body were centered around terror and fear of police brutality, as she was fully active in protests. Food and exercise was her drug of choice; she googled food and spirituality and found a retreat, which is where her healing journey began. She writes, “No matter my size, I was never satisfied with my weight...At one meeting, a women shared that the program not only helps us get free from unhealthy food behaviors, it also helps us develop a spirituality that works under all conditions ...In order to get the help I needed to heal my relationship with food and body, I needed to trust in a Higher Power who truly had my back” (150-152). Cleveland explains details of her healing journey, mainly consisting of daily body gratitude and affirmations in the mirror and seeing herself as divine. She talks about a “magical shift” (157) that happened for her after creating her own God that looked like her, and the power of seeing herself as a Divine God, which as she describes as a direct contrast from the Western image of the “whitemalegod.” She writes about discovering the Sacred Black Feminine:

First, I began by blatantly expressing what I *didn't* need in a Higher Power, especially one whom I was going to surrender my food behaviors...Even though I grew up in whitemalegod's world, it wasn't until that moment that I realized that I really, really, really hated *Him*. The Him whose fiery hoops I've been jumping through my whole life. The Him who told me that no one would want to marry me if I was fat...In order to get the help I needed to heal my relationship with food and body, I needed to trust in a Higher Power who truly had my back (151).

In rejecting the ‘whitemalegod’, Cleveland was able to affirm her own worth and divinity. She shares her mirror affirmations (152-153):

*I am worthy of a Higher Power who loves my Blackness.
I am worthy of a Higher Power who listens to, values, and validates my
experiences as a Black woman...*

I am worthy of a Higher Power who embraces my emotions no matter how loud they are...
I am worthy of a Higher Power who loves all of my body sizes...
I am worthy of a Higher Power who does not just listen to my experiences as a Black woman, she understands my experiences as a Black woman.
I am worthy of a Higher Power who knows the pain I face daily as a Black woman.
I am worthy of a Higher Power who stands beside me at the fatal intersection of white supremacy and patriarchy.
I am worthy of a Higher Power who exists in a body that is also scorned by the society.
I am worthy of a Higher Power who is a Black woman.

Ultimately, Cleveland's healing quest sent her on an intellectual and spiritual journey through history and across France to ancient shrines of the Black Madonnas. *The "evidence" of the Sacred Black Feminine (as if we needed evidence of her) lights up my soul and also makes me want to almost go on this 400 mile walking pilgrimage to these Black Madonnas. Until then, I will continue my mirror work to ignite and see the Sacred Black Feminine in me. I also had similar sentiments when I found out that my home state, California, is named after a thick Black queen, Queen Califa. I am also now determined to find the remnants of her up and down the west coast. I need to see her, as if she was this Divine mythical being, I feel like if I see her, I will see me. California is named after a big Black Queen? The same California that hated my big Black body? Oh I am definitely determined to lay my eyes on the Divine pieces left of her, and I am hoping that seeing her will help me to continue to connect even further to new levels of my own Divinity...*

Sonya Renee Taylor describes her own similar shift in thinking, from her body as a vessel to one that is, itself, holy:

The body is not to be prayed for but prayed to... the body is deity... the body is God....Radical Alchemy: Catalyzing Social Change through personal transformation...the manifestation of injustice and equity and discrimination in many ways is about our inability to make peace with the body our own bodies and other people's bodies and so through the work of

information dissemination education and community building we foster radical unapologetic self-love which we believe translates into radical human love in action in service toward a more just equitable and compassionate world that being motivated from here makes us want to do out there right. (Edmund Hillary Fellowship, 2017)

When you are navigating oppressive intersectional systems, your body has a response. Whether it's craving sugar, not eating, over-eating, drinking, substance use, etc., the thing or “drug of choice” as Cleveland states, the stress of navigating these systems takes a toll on Black women’s bodies. Many “health disparities” are clear results of the situation that (Redmond) Black women often deal with more than one form of systemic oppression. As our bodies feel dis-ease, disease manifests into the physical. As Solange sings about in her song, “Cranes in the Sky,” all of the stress and pressure can manifest itself in different ways:

I tried to drink it away
I tried to put one in the air
I tried to dance it away
I tried to change it with my hair
I ran my credit card bill up
Thought a new dress make it better
I tried to work it away
But that just made me even sadder

Michelle describes being confused by the complex relationships she saw between her mother and grandmother’s generation and their bodies. Whereas she knew their bodies as a source of comfort, as well as the “Lord’s Temple,” she also saw contradiction in the animosity towards their own bodies, or their only use as a recipient of the male gaze:

Your body was used as a means of getting a man, having sex. I remember, we used to sing in this choir and the song, My body is the Lord's temple. Don't mess with me, God's property. That was one of the lyrics of the song. It'll always be placed on the back of my mind because that was the only time in my life where I really understood your body is for you, yes, but God created you, like God created your body. How I like to interpret, how I like to view my body in that route is like there is a purpose for me outside of exploitation and objection from the male gaze and so yeah, body images was very distorted. It was very negative. We wasn't accepting of the bodies that we came in with. As I'd mentioned, both my family members decided to undergo surgery. Not to say that's a bad thing or diminish it, it is just as I told you from a previous conversation, I took comfort in my mother and my grandmother's bodies. When they held me or when we slept in the bed with each other like I was a child and I took comfort in their bodies. Growing up and seeing how much animosity that they had towards it confused me. I understand where that comes from my grandmother, she was ridiculed from having her body type. She was looked at as aggressive, domineering, dominating as a big Black woman. She played on that. She's like, you're going to look at me like that, all right, cool. I'm going to be exactly what you're telling me that I am. But when you speak to her one-on-one, she's just the sweetest thing such a shy little thing...But you wouldn't know that because when she was growing up in the '50s, '70s, like they were already on her neck...although I have more of my father's genes, I'm just trying to figure out my body for myself. Our bodies wasn't really discussed as we're discussing it right now, it was more from the lens of how many men who you can get and having sex with people and all that stuff.

I felt similar feelings as Michelle described her grandmother's body type and what society "expected". As a Black woman with a large body type I was never allowed to be "sweet" by my intimate household and social settings, not even as a child, I was always told that I was "too sensitive", "not assertive enough", "not aggressive enough". It was like a Black girl/woman couldn't possibly be gentle. It was like I wasn't allowed to be who I naturally was and I was taught this at a young age, but now I know better of course. As Michelle talked about her grandmother these feelings that have been buried up inside of me almost immediately came out. There was almost some closure to knowing that I wasn't the only one.

Michelle then explains about her future plans and future discussion with her children about seeing their bodies as Divine, especially Black women and girls specifically seeing their body as Divine. I believe her childhood experience explains her wanting this for her daughter:

You have agency and autonomy over yourself. I think that's definitely something that I would like to instill in my daughter in particular, and my son too. But for my daughter especially...But it's important for Black young girls to understand that your body is your own and nobody else's. If you want to view it as God's temple. What I mean by that, it just means your body is divine, is sacred. Especially the female anatomy. It's so beautiful and it's so sacred, and I feel like we're not told that enough. We're just told that is good for fucking and sucking, when it's not, it's more than that. To hit it on a spiritual term, it's maybe where to save it. It's like your avatar, this is your only body in this lifetime, why are you going to treat it with such disdain? You have to get to know it, you have to honor it, because this is you, this is a part of you, but it's not the only thing that makes you, you. You can dress it up if you want to. You can put on the accessories and shit if you want to. But again, at the end of the day, we all have to unroll, and we all have to get undressed and we look at ourselves in the mirror and see what we see, and I hope with or without clothes on you see yourself as somebody of importance and your body is a means to be nurtured on, not abused.

Manifesting seems to be the new age word for having *unwavering* faith that your dreams and heart's desires will come true. *'Faith' is what guided me to my healing journey. In the middle of the 2020 pandemic, dealing with postpartum depression, and being a single mom, full time student, having no family in the area, with no joy, hope or faith left, especially in the "criminal justice system," I found myself scrolling through Instagram. I came across my childhood youth pastor providing positive messages to her followers. Her dynamic spirit and her positive, uplifting words graced the dimensions of Instagram. I said to myself, "I need some of that positive energy." I sent her a direct message, asking, "How do I have faith when all faith has left me..." and began to pour out all of my troubles. She had been life coaching since I have known her. She answered me by saying, "I think you would benefit from having a few sessions with me." This was the start of my healing journey. Those first few sessions were centered in learning the true concept of self-love and me healing from internalized racialized belief systems within myself (I of course didn't recognize that at the time but as I reflect that is definitely the language for it). As I moved through the process, I wanted to share this gift of healing with every Black woman I knew; it is what I needed, to be seen and sent love in a society that wasn't giving love to me. My number one goal was to find healing and to give the gift of healing to other Black women in this project.*

Chapter V

Conclusion

This project qualitatively examines how a society that is built on racialized, gendered and fatphobic systems has directly affected how the Black woman's body is interpreted as unhealthy and diseased by social and medical professionals, and how that body is then treated as a result. In this study, I have examined how Black women navigate and interpret their medical and social experiences. I have created a Gender Race Weight matrix, which functioned as the interview guide for this study's interview process, to map out and highlight the tangled web that Black women navigate in these spaces. This project also utilizes Black feminisms and medical sociology to illustrate the false and deficit narratives of Black women, as well as show possible available avenues of healing.

As discussed in Chapters 1 and 2, stereotypes have historically been the driving force and used to justify the treatment of Black women's bodies throughout society. These stereotypes, the labeling and degradation of Black women's bodies, were reinforced during the time of Black people's enslavement and have been ingrained into the structure of society. Deborah Gray White (1999) insisted that "African and African American women were not born degraded, but rendered so by enslavement" (8). False and deficit narratives, such as the food insecurity-obesity paradox (FIOB), are derived from these stereotypes and cause harm to Black women and girls. They also contribute to contemporary health disparities and medical mistreatment that Black women and girls are still experiencing.

I have developed the term the Crooked Room of Medicine (CRoM) to describe the mental, emotional, and physical struggles Black women face at the intersection of race and gender stereotypes/false narratives, particularly in medical settings. In the CRoM, Black women have

historically suffered and been erased. It is important to change narratives of Black women and girls, especially within medical spaces where they can be easily misdiagnosed, lose their lives, or simply just internalize negative experiences. Changing the narrative of Black women and girls is a part of personal and collective healing (Harris 2021). Changing narratives is not only a part of healing, but also about saving lives.

My interviews sought to elucidate Black women's experiences around health, race and body size, and explore how the the social domains of intimate households, community and social/medical spaces influence these experiences in relation to time (past, present, and future). Another purpose of conducting interviews was to examine how these experiences impacted the participants' perception of themselves and how they continue to navigate society (intimate, community, and social/medical). My findings show that regardless of weight, size and socioeconomic status, Black women have endured and still continue to endure traumatic experiences from CRoM, which they are seeking ways to heal from.

During this project, Cottom (2019) deepened my interest in the term "thick" as a metaphor, particularly when she called for an examination of "fat" Black women using a thick lens through thick studies. Cottom writes, "I hope we build a body politic so thick with nuance and humanity and blackness (because blackness is humanity), that no black woman public intellectual has to fix her feet ever again to walk this world" (2019, 32). A thick analysis provides space to examine how Black women historically and contemporarily have rejected the negative connotations associated with tropes applied to Black women and their bodies, as well as reclaimed those tropes for their own use. Acknowledging how the past informs the present, it is important to incorporate thick analysis when examining Black women's health, and to take a holistic approach that incorporates all aspects of life and well-being, as Black women have not

only endured a lot of obstacles in all dimensions in life, but considering the spiritual dimension of health, may even carry some intergenerational racialized trauma (Laymon 2018; Ford 2021; Coleman 2022), as discussed in Chapter 3, under Thick Methodology and Embodiment of (generational) heaviness. I utilized Thick Studies to develop the Gender Race Weight (GRW) Matrix to map out our experiences and develop a theory that is healing, in part to rewrite the effects of deficit narratives.

I argue for holistic health approaches and treatment for Black women, espousing the idea that each human being is composed of physical, mental, emotional, and spiritual dimensions (Lawrence 1998; Iqbal 2013). The crooked room and the Crooked Room of Medicine affects physical, emotional, mental, and spiritual aspects of Black womanhood, as well as produces shame (Harris-Perry 2011) as Black women internalize the narratives of crooked rooms. Therefore, in order to address this shame, we need to have a holistic approach to Black women's health.

Furthermore, the overall purpose and intention of this work is to debunk medical providers' adherence to false deficit narratives and bias, such as the FIOB, which lead to miscommunication and misunderstanding, ultimately impacting medical treatment decision-making and unfavorable outcomes for Black women (Sheppard, Adams, Lamdan, & Taylor 2011; Agénor, Bailey, Krieger, Austin & Gottlieb 2015; Doll 2018).

What I lay out as thick studies, including my theorizing of the Crooked Room of Medicine and the ways in which I lay out the Gender, Race, Weight matrix, will allow Black women to see themselves and their own bodies, to define their own bodies outside of categories of "obese," "overweight," "fat," and even "thick," and show Black women that aspects of health do not align with a number, category, or percentile. I am hopeful that my study will show that Black women

need to reject labels of disease or pathologization to better advocate for themselves in medical spaces. My study also seeks to provide a holistic exploration of health that addresses health on all levels (emotional, mental, physical, spiritual), not just physical Western beauty standards with regard to how Black women engage with medical institutions.

When I first conceived of this project, it was conceived in pieces, and built upon my experiences as a young Black girl, to a Black woman staring in a doctor's office, to a Black woman in graduate school, to a Black single mother. This project was also built on witnessing my mother's experiences in medical spaces, as well as the experiences of other Black women I know. This project was built from overhearing my mother frustratingly talk about her experiences to her other Black women friends, as they frustratingly shared experiences over the phone with each other. This project was built on pieces of me. I'm not sure which is more difficult, to experience racialized and gendered injustices or watching women that look like me experience racialized gendered and even fatphobic injustice, especially in medical spaces, where you are supposed to be the most cared for. As Black feminists before me, this work was built out of frustration... frustration from systems that hurt and harm women that look like me.

Limitations

This study had a high response rate; it was interesting to see that my sample size included so many women with Phds, and more than half of the sample size were women that were at least college educated (see table 1). This makes me question even further why these Black women with Phds, upon walking in medical spaces, were often treated as if they had "no brain". I also directly sent flyers to women with and without college education. I wonder if the history of research, abuse and experimentation with Black people in the U.S. influenced my sample size and the demographic that participated. After bearing witness to the poor treatment Black women with

PhDs received, I can only imagine how Black women without degrees may be even more marginalized, which is terrifying. Another limitation is that I ended up with so much data, some outside the scope of the GRW matrix that I had not anticipated and so I was not able to focus as much on it in the findings. Also, even though this is pilot qualitative data, I understand that reporting on the interviews of as few as 12 women is not generalizable. Because I mostly heard from privileged Black women and that was the dominant voice in this study, more data that needs to be collected from those not represented here in regards to race, class, body size and medical experiences.

Future Directions

This project seeks to give Black thick women permission to embrace all parts of themselves while rejecting social standards. It seeks to provide language that helps Black women embrace all aspects of themselves as whole. This work also holds out hope for future inclusion of all aspects of feminism, Blackness, and health. Because this research is so complex, intertwined and layered and it took layers of systems of oppression and time for us to get here it will require layers of interdisciplinary work and future research and implications with care and intentionality incorporated in next steps of this work. Contemporarily, we also see Chritina Sharpe's theory of Black redaction and annotation play out in the discussion of Black women's maternal mortality rates as Louisiana Senator Bill Cassidy said in an interview with POLITICO for the Harvard Chan School of Public Health series,

About a third of our population is African American; African Americans have a higher incidence of maternal mortality. So if you correct our population for race, we're not as much of an outlier as it'd otherwise appear

So quickly, within seconds, Black women were redacted and ignored for his political agenda and the CRoM is ignored again. The United States had the worst maternal mortality rate among

developed nations, with rates much more common among Black women, Louisiana's health department says it outpaces other states (POLITICO). A national crisis that affects Black women directly in CRoM quickly redacted out of space and time is the perfect example of what this project is aimed to address. And it will take interdisciplinary approaches, all hands on deck to truly address these issues of CRoM.

I would also like to expand on the *heaviness* work in regard to racial generational trauma within inclusion of other gender identities and what layers of various gender identities within Blackness brings to the heaviness.

The next steps for this project will be to rework the GRW matrix, including direct questions about healing work and racial healing; “What does healing look like for you?” “What are your thoughts on healing?” “Have you started a healing process/journey?” Also extending healing questions to the past, community, and social/medical sections of the matrix. The reflective part of this work is the continuation of my personal healing journey and healing for my family as a whole from the crooked room of justice, as our whole family will need therapy and need to heal from this experience. During my partner’s incarceration, he spent sixteen weeks in solitary confinement for no legitimate reason. Currently, there are a lot of conversations and laws being passed regarding solitary confinement and how it destroys the mental health of a person even more than normal jail and prison time. As we know, mass incarceration and Blackness are unfortunately not separate; I spent a lot of time finding coalition support and resources for my partner and family. Even after he is released, I know we will need to spend time and energy in order to heal from this, and I would like to share those resources and open up the work for more marginalized voices in academic spaces, especially for the women at both ends of mass

incarnation. Healing justice and transitional justice are areas of research that parts of this work can help inform and grow and that I would like to expand to as well.

I hope this work of a thick analysis and Thick Studies opens up space to discuss the layers and complexities of Blackness, health and mass incarceration and its effects and impacts on single Black mothers and families as a whole. I hope Thick Studies is a space that includes and welcomes all Black voices from various socioeconomic backgrounds to include aspects of healing for Black women and families that have been gobbled up or are currently being gobbled up by mass incarceration and other crooked rooms. It is very difficult to be holistically healthy and Black in the time of mass incarceration, as it affects all parts of the human design and the family as a whole.

The next steps of this work and study will consider different forms of healing and what that looks like for the different folks across the Diaspora: dance, womb healing, art, music, self-care, community healing and support and what all of these may look like. Lastly, the future directions for this work and study would be to explore medical advocacy. There is plenty of research on health inequalities and racial inequalities in medical spaces, as well as medical advocacy (Lee 2020). So, for me, the next steps are exploring how we can get advocates in various socioeconomic spaces, as well as more exploration in medical advocacy and Black feminisms.

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Appendix A IRB Approval letter



Division of Scholarly Integrity and
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MEMORANDUM

DATE: March 25, 2022
TO: Andrea N Baldwin, Christine Labuski, Jariah Li'Shey Strozier
FROM: Virginia Tech Institutional Review Board (FWA00000572)
PROTOCOL TITLE: A Black Feminist's Critique of the Crooked Room of Medicine (CRoM),

Innovation of Thick Studies and the Gender, Race, Weight Matrix

IRB NUMBER: 22-025

Effective March 25, 2022, the Virginia Tech Human Research Protection Program (HRPP) determined that this protocol meets the criteria for exemption from IRB review under 45 CFR 46.104(d) category(ies) 2(ii)

Ongoing IRB review and approval by this organization is not required. This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these activities impact the exempt determination, please submit an amendment to the HRPP for a determination.

This exempt determination does not apply to any collaborating institution(s). The Virginia Tech HRPP and IRB cannot provide an exemption that overrides the jurisdiction of a local IRB or other institutional mechanism for determining exemptions.

All investigators (listed above) are required to comply with the researcher requirements outlined at: <https://secure.research.vt.edu/external/irb/responsibilities.htm>

Please review responsibilities before beginning your research.

PROTOCOL INFORMATION:

Determined As: **Exempt, under 45 CFR 46.104(d) category(ies) 2(ii)**

Protocol Determination Date: **March 25, 2022**

ASSOCIATED FUNDING:

The table on the following page indicates whether grant proposals are related to this protocol, and which of the listed proposals, if any, have been compared to this protocol, if required.

Invent the Future

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
An equal opportunity, affirmative action institution

Appendix B
VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Title of research study: A Black Feminist's Critique of the Crooked Room of Medicine (CRoM), Innovation of Thick Studies and the Gender, Race, Weight Matrix

IRB #: 22-025

Dear _____,

My name is Jariah Li'Shey Strozier. I am a doctoral student in the Department of Sociology at Virginia Tech. I am conducting research that examines Black Women's medical experiences related to their gender, race and weight. My research, entitled *A Black Feminist's Critique of the Crooked Room of Medicine (CRoM), Innovation of Thick Studies and the Gender, Race, Weight Matrix* IRB # 22-025, is an interdisciplinary critique of false narratives about Black women, including medically "legitimate" ones like the Food -Insecurity Obesity Paradox. First described by physician William Dietz in 1995, the "Food Insecurity-Obesity Paradox" (FIOP) attempts to explain the biology and behaviors of people who are simultaneously overweight and food-insecure; these people are very often Black women who are the primary breadwinners of their households. Via critical analysis of these narratives, and employing Black feminist and medical sociological perspectives, I explore how stereotypes of Black women correlate with how Black women's gender, race, and weight are interpreted and "treated" in social and medical settings.

In short, this study is about Black women and health through the lens of weight. My work emphasizes a holistic approach to the study of Black women's health and makes a unique contribution to sociology and health fields as it draws upon various Black feminist theoretical and methodological approaches in order to create a fuller understanding of what Black women's health could mean.

By speaking to Black women privately and directly about their experiences via one-on-one interviews, I intend to listen to my study participants, and to hear their experiences in a safe, non-judgmental environment. Responses from this research will use pseudonyms chosen by participants to quote any specific woman but will speak collectively about their experiences. The interviews will last between 30 and 90 minutes and will be audio recorded.

If you are interested in more information, I will be willing to provide you with additional background about my research and to set up a time convenient for us to meet face-to-face or to talk on the phone.

I appreciate your time and consideration. I can be contacted via email at jariahls@vt.edu or mobile phone at 805- 236-3744.

Sincerely,
Jariah L. Strozier

Appendix C

Gender Race Weight Matrix Interview Guide

Research questions:

- 1) What are Black women's experiences around health, race, and body size?
- 2) How are these experiences influenced by
 - a) a) intimate,
 - b) b) community,
 - c) social/medical?
- 3) How have these experiences impacted their perception of themselves and how they navigate society including:
 - a) a) intimate,
 - b) b) community,
 - c) social/medical?

To answer these questions, I developed the GRW matrix

Holism: body, mind, spirituality and emotional

Level	Past (A)	Present (B) (reflection?)	Future (C)
Intimate household (parents, guardians, household members, family, grandparents, spouses, intimate partners)	Past experience with gender, race and weight. Growing up... with immediate family themes: -past household/generational habits/beliefs/ideas of GRW	Current experiences with gender, race, and weight and how past experiences may have impacted present themes: -current coping habits from past experiences -how past affects current life -generational health issues or symptoms	Future actions/attitude/goals in regards to gender, race, weight for you and your intimate household themes: -breaking cycles from past/generational way of coping with life (binge eating, etc)...to more holistic (stirring away from the word 'healthy') balanced habits
Community (neighbors, neighborhood, residential, school, friends, classmates, community orgs/spaces, community leaders, authority figures, neighborhood friends, work environment, coworkers)	Past community experiences with gender, race, weight themes: -past community habits/beliefs/ideas of GRW/Black woman (girl)hood/'thick' Black(girl)hood	Current community experiences with gender race weight and how past may have impacted present themes: - community/workspace affirm Black womanhood	Future actions/attitude/goals for your community spaces/friend groups/organizations/networks with gender, race, and weight themes: -future goals/attitudes/actions to affirm Black womanhood (live/move to spaces that affirm) -affirm 'thick' Black womanhood
Social/Medical sphere (media, social media, social media)	Past interactions/experiences with social and medical spaces with gender, race, weight	Current relationship with social and medical spaces in regards to gender, race and weight, past	Future action/attitudes/goals with medical and social spaces in regards to gender,

networks, public spaces, public agencies, social services/government spaces, medical spaces, urgent cares.)	Themes: -past misunderstandings/stereotypes/miscommunication with medical or social spaces due to being a 'thick' Blackwoman	impact on present themes: - misunderstandings/stereotypes/miscommunication with medical or social spaces due to being a 'thick' Blackwoman	race weight Themes: -goals plans to seek medical care and social spaces (including social media spaces) that affirm or knowledgeable of Black womanhood experiences -holistic health consideration
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