Eating Disorder Training for Community Providers

Weight Stigma, Health Care, and the Food Environment

Therese Waterhous, PhD, RDN, CEDS, FAED (She/Her)
tswaterhous@gmail.com

Learning Objectives

- Identify Weight Stigma in your own work, workplace and life.
- Understand the effects of systemic weight stigma and weight bias on the health of the population.
- Learn ways to incorporate weight inclusiveness into your work and work environment.
- Identify problems in the food environment, food marketing and messaging about food and how conflicting messages impact people's stress and health.
- Be able to describe how dieting contributes to metabolic dysregulation.
- Be able to access resources to enable you and others you interact with to learn more about weight stigma, weight inclusive practices and fat activism.

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Handouts

- ‘You Don’t Look Anorexic’ New research shows that our assumptions about eating disorders are often wrong — and that many larger-bodied people are starving themselves. Oct. 18, 2022 https://www.nytimes.com/2022/10/18/magazine/anorexia-obesity-eating-disorder.html
- Management of eating disorders for people with higher weight: clinical practice guideline. J Eat Disord. 2022; 10: 121. Published online 2022 Aug 18. https://doi.org/10.1186%2Fs40337-022-00622-w
- Weight Inclusivity Handout
- Blog from the Association for Size Diversity and Health. https://asdah.org/eating-disorders-are-an-active-trauma-not-a-maladaptive-coping-strategy/

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Terms: Weight Stigma, Weight Bias, Thin Privilege

- **Weight stigma** – Weight stigma is discrimination or prejudice against individuals based on their weight. This can manifest as fatphobia, weight bullying, and assumptions about an individual's health or character.

- **Weight Bias** – One's internalized beliefs and feelings about weight. These internalized beliefs might be unconscious.

- **Fatphobic** – Fear of weight gain and fear of fat people plus fear of what weight gain will do to you, both physically, mentally, socially.

- **Weight neutral** – The weight neutral approach does not use weight alone as a measure of health or a goal. Weight-neutral or weight-inclusive approaches start from the premise that all bodies are good bodies and deserving of respect.

Terms: Weight Stigma, Weight Bias, Thin Privilege

- **Diet culture** – a culture containing beliefs that center around thinness and equate it with health, self control and moral virtue while holding negative views of fatness. Diet culture values weight loss and works to avoid weight gain. Diet culture contains many untrue assumptions such as the "calories in-calories out" myth.

- **Healthism** – This embodies the idea that being healthy is better and under one's full control .It also holds the idea that a person's health and wellness are entirely their responsibility, ignoring external factors that are outside of their control, such as access to a grocery store or a life free from mental stressors.

- **Body privilege** – Your weight has not been a barrier to success on many levels, including social acceptance. Your weight is not discussed as a problem by healthcare providers. You have not experienced weight stigma, and your body size isn't a consideration for how you experience things. Your body size does not factor into your quality of life.

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What is True?

- Weight stigma, or sizeism, is discrimination based on a person's weight. It is reported at rates comparable to racism and is one of the last types of discrimination still condoned and carried out by public health and medical experts.
- The incidence of weight stigma has increased over time, with the rise of public health campaigns to end the "obesity epidemic".
- Weight stigma is harmful to health, and often not included as a variable in research studies looking at health behaviors and trends.
- Weight stigma is positively correlated with a variety of disordered eating patterns such as binge eating, restrictive eating, weight cycling and eating anxiety.
- Dieting does not work.
- One's weight is not completely under one's control. It is the result of a complex mix of environment, stressors, genetics, movement and other factors.

From: PUBLIC HEALTH NEEDS TO DECOUPLE WEIGHT AND HEALTHPOLICY BRIEF. UIC School of Public Health ~ Collaboratory for Health Justice. Amanda Montgomery, RD, LDN

Weight Stigma

- Experiencing weight stigma not only increases one's risk for negative health outcomes, it also leads to health care avoidance by people with larger bodies, increasing the chances that they do not receive preventative care services (e.g. cancer screenings).
- In children, weight-based bullying is one of the most frequent types of bullying experienced in school. One study showed a strong association between childhood bullying and binge eating and bulimia.
- Weight stigma is extremely stressful. The stress and resultant high levels of cortisol promote: Inflammation, high blood pressure, increased blood sugar and risk of Type 2 Diabetes, depression, lower self-esteem, body image dissatisfaction, disordered eating behaviors.
- Weight stigma often leads to recommendations from health care providers to lose weight.

https://www.apa.org/monitor/2022/03/news-weight-stigma

How Does Weight Stigma Show Up?

- **Isn't it better to be thin? = weight bias**
- Assumptions about weight and it's direct effect on health
- Lack of spaces, clothing that fit larger bodies
- Comments about one's weight, often guised as concerns about one's health
- Comments on one's food choices or food intake
- Compliments on one's weight loss (never mind what caused it)
- Statements linking any medical or mental condition to one's weight
- Being made fun of or being bullied because of how one's body is
- Toxic work environments (diet contests)
- Media images and messages

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Assumptions Regarding Weight and Health

- That higher weight is the cause of poor health
- That long term sustained weight loss is achievable
- That weight loss results in consistent improvements to health
- That weight stigma will motivate people to want to lose weight
- Accurate perception (measurement) of weight or degree of adiposity is necessary to promote health
- In truth, weight stigma, independent of adiposity, positively correlates with increased stress hormone levels. Stress has been found to impact multiple areas of health such as blood pressure, cardiac health, visceral fat levels and insulin resistance.

Hunger JM, Smith JP and Tomiyama J. An Evidenced Based Rationale for Adopting Weight Inclusive Health Policy. 2020. Social Issues and Policy Review. 14:1; 73-107

What is the BMI?

- The Body Mass Index or BMI was developed by Adolph Quetelet in the 1830's, with the goal of finding the "perfect human". He mainly was looking to define "ideal" based on European white men.

- Mr. Quetelet did not intend for the BMI to be used for medical purposes. His sample population only included white French and Scottish men, thus, the BMI is not representative of the entire human population.

- The BMI became popular in the early 20th century when it was discovered by life insurance companies, who used it to set insurance premiums for their clients.

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What is the BMI?

- Insurance companies saw a relationship in some people, between weight and mortality, although their sampling included only insurance company clients who self-reported their heights and weights. The BMI was quick to calculate and easy to use so it soon became favored as a tool to determine health.

- The BMI does not consider health behaviors (e.g. stress, nutrition, physical activity, sleep patterns) or body composition (e.g. bone, muscle, and fat mass). Therefore, it leaves out variables that also affect health.

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The Weight Focus

- Focusing on weight alone or using the Body Mass Index (BMI) to assess health, underdiagnoses thin people and misdiagnoses larger people.

- A study of 40,420 U.S. adults using National Health and Nutrition Examination Survey (NHANES) data from 2005-2012 looked at health stratified by BMI and found:

  – Nearly 50% of overweight individuals, 29% of obese individuals and 16% of obesity type 2/3 individuals were "metabolically" healthy

  – Over 30% of normal weight individuals were "metabolically unhealthy"

Tomiyama, A. J., Hunger, J. M., Nguyen-Cuu, J., & Wells, C. (2016). Misclassification of cardiometabolic health when using body mass index categories in NHANES 2005-2012. International journal of obesity (2005), 40(5), 883–886. https://doi.org/10.1038/ijo.2016.17

Misdiagnosis

- If extrapolated to the US population, an estimated 74,936,678 US adults are misclassified as unhealthy or healthy if based on BMI alone.

- Another analysis of NHANES data showed that those in the overweight BMI category actually have the greatest longevity out of any BMI group, again contradicting the idea that BMI directly indicates health status.

- When the medical system uses BMI as a health indicator, it can lead to misdiagnosis for people in larger bodies – with the risk of real medical concerns being overlooked as the focus is placed on weight or weight loss.

- Similarly, people in thinner bodies are often under diagnosed due to an assumption of good health.

From-PUBLIC HEALTH NEEDS TO DECOUPLE WEIGHT AND HEALTHPOLICY BRIEF. UIC School of Public Health ~ Collaboratory for Health Justice, Amanda Montgomery, RD, LDN

Flegal, K. M., Graubard, B. I., Williamson, D. F., & Gail, M. H. (2005). Excess deaths associated with underweight, overweight, and obesity. JAMA, 293(15), 1861–1867 https://doi.org/10.1001/jama.293.15.1861

McGee, D. L., & Diverse Populations Collaboration (2005). Body mass index and mortality: a meta-analysis based on person-level data from twenty-six observational studies. Annals ofepidemiology, 15(2), 87–97. https://doi.org/10.1016/j.annepidem.2004.05.012

Weight and Health

- There is a correlation between higher BMI and worse health outcomes, yet this does not mean more body fat in and of itself is causative.
- A person in a larger body may or may not engage in other behaviors that are either good or bad for health. These other factors must be included in research.
- Factors such as ability to exercise, access to food/food insecurity need to be included in research. The “obesity paradox” is seen in people experiencing food insecurity and who also have larger bodies.
- Research studies exploring the relationship between weight and health should be assessed for quality in terms of study length and attrition. Research also needs to look at “confounders” including weight cycling, weight stigma, and trauma, variables often experienced by people in larger bodies and which impact health outcomes.

KM Lee, JM Hunger, J Tomiyama. Weight Stigma and Health behaviors: Evidence from the Eating in America Study. 2021. Int J Obes. 45(7): 1499-1509 PMID:33934109 PMCID: PMC8236399

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Eating Disorders and the Thin Ideal

- Rates of eating disorders/disordered eating are increasing. Dieting and body dissatisfaction are strong risk factors for disordered eating and eating disorders.
- "Disordered eating" is not diagnosed according to the DSM-5 criteria. However, both disordered eating and eating disorders can have profound negative effects on mental and physical health.
- Disordered eating is chaotic eating. Behaviors include:
  - frequent dieting
  - fasting
  - chronic restrained eating
  - restricting major food groups
  - bingeing, and/or using vomiting and laxatives
  - anxiety associated with specific foods or feelings of guilt and shame associated with eating
  - chronic weight fluctuations
  - rigid rituals and routines surrounding food and exercise
  - preoccupation with food, weight and body image that negatively impacts quality of life
  - a feeling of loss of control around food, including compulsive eating habits, using exercise, food restriction, fasting or purging to "make up for bad foods" consumed

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Weight Loss Intervention Studies

- Intentional weight loss has a 90% failure rate.
- Short term weight loss studies indicate that participants lose ~5-10% of their baseline weight . However, long term studies indicate that regardless of initial weight loss, most people regain that weight after 2 years, with up to 65% of dieters likely to regain more weight than they lost on their diets.
- If these data were used to evaluate prescription drugs, those drugs would never be considered for use.
- Studies evaluating the effectiveness of weight loss interventions often do not report the high attrition rates.

Weight Loss Intervention Studies

- Some weight loss studies include multiple interventions (e.g., diet, exercise, smoking cessation) or rigorous (not realistic, very fast weight loss) interventions. This can make them difficult to evaluate.

- Many studies are of short duration (many studies only last ~6 months) and do not include long term follow up.

- Much of the obesity research in the U.S. is funded by weight loss and drug companies, such as Weight Watchers and Abbott Laboratories - thus influencing the types of studies being done.

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Restriction of Food Intake

- Food restriction and dieting have detrimental effects on metabolism and physiology.

- The body interprets dieting/restriction of food intake as impending starvation. When we restrict food, we alter the body's natural hunger and fullness cues, making us more susceptible to outside food cues.

- In addition, hormonal changes occur in an attempt to reduce weight loss, producing more hormones that make us feel hungry, fewer hormones that promote fullness and increasing our cravings for carbohydrate foods.

- A study of participants in "The Biggest Loser" found that 6 years after their weight loss, the 14 participants had regained much of the weight lost, and metabolic slowing was still present, with those that maintained the greatest weight lost having the greatest degree of metabolic slowing.

Fothergill et al, 2016, PMID: 27136388

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Food Restriction

- Ancel Keys' Minnesota Starvation Experiment found that men who spent 3 months on a semi-starvation diet (1700 kcal/day) developed these symptoms:
  - Significant decreases in strength/stamina, body temp, heart rate, sex drive and mental ability
  - Increases in fatigue, irritability, depression and apathy
  - Obsession with food (dreaming/fantasizing about food, reading and talking about food nonstop)

- The Minnesota Starvation Experiment also gave us information about the obsessions seen in starvation and how these are very much like the obsessions seen in Anorexia Nervosa.

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Dieting Behaviors and Eating Disorders

- Almost 70% of Americans have dieted in some form.
- 65% of American women ages 25-45 have disordered eating, and 10% have a diagnosed eating disorder.
- By age 9, 50% of girls have considered restricting food.
- People of color experience eating disorders such as bulimia and binge eating disorder at higher rates than their white counterparts. However, they are more likely to be underdiagnosed, which can occur due to misconceptions about who gets eating disorders.
- People with “Atypical” Anorexia Nervosa, where a person’s weight is not low, are frequently underdiagnosed, yet are very sick.
- Food restriction, in those genetically predisposed to an eating disorder, can initiate the cascade of neurobiological changes that promote eating disorders.

Reba-Harrelson, L., Von Holle, A., Hamer, R. M., Swann, R., Reyes, M. L., & Bulik, C. M. (2009). Patterns and prevalence of disordered eating and weight control behaviors in women ages 25-45.Eating and weight disorders : EWD, 14(4), e190–e198. https://doi.org/10.1007/BF03325116

Goeree, Michelle Sovinsky and Ham, John C. and Iorio, Daniela, Race, Social Class, and Bulimia Nervosa. IZA Discussion Paper No. 5823, Available at SSRN: https://ssrn.com/abstract=1877636

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Weight Cycling

- Weight cycling, or the repeated loss and regain of weight, is associated with poorer health status and weight cycling has increased over time as the number of people "on a diet" has increased over time.
- Weight cycling is more commonly seen in people in larger bodies, due to the societal expectations that they lose weight or be "working on their health".
- Despite weight cycling's detrimental effects on health, it is often not considered as a confounding factor in research that investigates the relationship between body size and health.
- Therefore, it is hard to say for certain whether worse health outcomes in larger-bodied people are due to weight itself, or due to confounders such as weight cycling.

Montgomery, Amanda; Collaboratory for Health Justice (2021): Public Health Needs to Decouple Weight and Health. University of Illinois at Chicago. Educational resource. https://doi.org/10.25417/uic.16823341.v1

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Weight Cycling

- Weight cycling is associated with increased all-cause mortality- mortality from cardiovascular disease, risk for heart attack, stroke, diabetes, high blood pressure, and suppressed immune function.
- The desire to lose weight affects both young and old people. Multiple studies performed in young adolescents and young girls showed that around 40%–50% of young girls want to lose weight and want to become like media figures.
- The reporting on the “Childhood Obesity Epidemic” caused many parents to restrict food, or certain foods, or shame their children, especially if parents were told by pediatricians that their child’s weight was increasing.
- The rate of preoccupation with body weight leading to dieting and weight cycling are also high in older women. In a study from NHANES, the prevalence of older people (≥55 years) who desired to weigh less was almost similar to that seen in younger people (<55 years), around 70% vs. 75% among women and 59% vs. 54% among men.

Eun-Jung Rhee. Weight Cycling and its Cardiometabolic Impact J Obes Metab Syndr. 2017 Dec; 26(4): 237–242. Published online 2017 Dec 30. https://doi.org/10.7570/jomes.2017.26.4.237 PMCID: PMC6489475 PMID: 31089525

What is it about Fat that People Do Not Like?

- Is there an esthetic aspect? How do we learn about attractiveness?
- Is it all about health?
- Is it some of the perceptions, taught to us over the years, that being a certain degree of fatness denotes a person who is lazy, out of control, lacks will power?
- Has the Thin Ideal been used to rationalize treatment of marginalized groups?
- Women historically have been the focus of body shaming. Women often try to achieve a body type in order to appease family members, spouses or gain social acceptance.
- The Thin Ideal has caught up to men and boys.

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Desirability Politics

- Larger bodies once signified wealth and prosperity while thinness signified poverty and weakness.
- Charles Darwin and other scientists who looked at various ethnic groups created a hierarchy of civilization, placing white men on top and people of color, specifically black people, at the bottom, considering them to be “less civilized.”
- Fatness became used as a marker of “uncivilized behavior” while thinness was “more evolved". This idea was maintained throughout the United States in the 19th and 20th centuries. The early thin ideal was used to justify slavery, racism and classism, and control women through "temperance".
- This ideology has perpetuated Desirability Politics or “Pretty Privilege”- where thinness, whiteness and perceived attractiveness are given more access to social, political and cultural capital.

Montgomery, Amanda; Collaboratory for Health Justice (2021): Public Health Needs to Decouple Weight and Health. University of Illinois at Chicago. Educational resource. https://doi.org/10.25417/uic.16823341.v1

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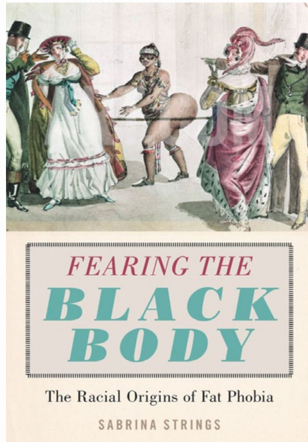
Some History of Body Preferences



According to Sabrina Strings, author of "Fearing the Black Body: The Racial Origins of Fat Phobia," fatphobia has its roots in the transatlantic slave trade, in which colonists asserted that Black people were prone to gluttony and sexual excess, and that their love of food caused them to be fat.

- European colonists claimed a moral superiority, valuing moderation and self-control, which made them thin, and, according to them, "the superior race."
- By the early 1800s, fatness was considered a sign of immorality in the U.S., as well as racial inferiority.

From: https://withinhealth.com/learn/articles/the-racist-history-of-fatphobia-and-weight-stigma

The "Micro Stressors" of our Food Environment

- Looking at our food supply in the United States and other developed countries, we can see that if a person has adequate financial resources, the food options are nearly limitless.
- Lot of choices. Is this always desirable?
- What types of stress are produced when one has to constantly evaluate food choices? Dependent on one's temperament, having a lot of choices may result in extreme stress.
- The perfect storm: lots of food choices, lots of food marketing and manipulation, and lots of pressure to not eat, in order to meet the Thin Ideal.
- Since 1980, public health studies have documented the increase in weight in children and the general population of the US. What changed? Did people's genetics change? Did people's will power change? Enter the microwave.

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Food Marketing and Food Manipulation

- Food is the most advertised commodity in the United States.

- Food corporations spend on average over $36 billion a year on marketing and advertising. Seventy percent of total advertising goes to market convenience foods, candy, snacks, soft drinks, desserts and alcohol.

- As a result of the wide range of marketing on an even wider range of products, consumers have been taught to feel they have a considerable amount of choice.

Garavente, Angelina, "How Has The Food Industry Manipulated The Way Consumers Perceive Food And Health?" (2018). Honors College Theses. 173. https://digitalcommons.pace.edu/honorscollege_theses/173

Albritton, Robert. "FOOD, MARKETING AND CHOICE IN THE UNITED STATES." Let Them Eat Junk: How Capitalism Creates Hunger and Obesity, Pluto Press, London; New York, 2009, pp. 165–181. JSTOR, www.jstor.org/stable/j.ctt183pbv8.10.

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Weight Centric/Normative vs. Weight Inclusive Care

- Weight centric care looks at weight first as central to health care. Weight is discussed first in many encounters.
- Weight loss is prescribed first, no matter what else is going on in a person's life. Why prescribe something with a 90% failure rate?
- What else can you do? First, find out what is important to a person. What do they want to work on in terms of health? Do things with them, not to them. This is trauma informed care.
- Discover what behaviors /activities can lead them towards those goals. What can they actually change? Weight is not likely to be something they can change.
- Leave WEIGHT out of the goal setting! Do not imply that their weight is a cause of something. This leads to shame, because often they can't change their body's weight.
- As health care providers we have to learn to talk differently!

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Weight Inclusive Approach

- The weight-inclusive approach assumes that everybody is capable of achieving health and well-being independent of weight, given access to non-stigmatizing health care.
- This challenges the belief that a certain weight reflects a particular set of health practices, health status, or moral character.
- Weight is not viewed as a behavior, but these are behaviors: eating nutritious food when hungry, ceasing to eat when you have had enough, sleeping well, taking one's meds as prescribed, managing stress, and engaging in pleasurable (and thus more sustainable) exercise --are self-care behaviors that can be made more accessible for people.
- Even so, the above might be ignoring a person's life or state or choice.
- The Health At Every Size approach rests on the evidence that while extremes of weight and health problems are correlated, evidence for the role of factors other than weight in people's health is stronger. Focus needs to shift to root causes of health and social determinants of health.

Weight Inclusive Approach

- Work to increase health access, autonomy, and social justice for all individuals along the entire weight spectrum. Trust that people move toward greater health when given access to stigma-free health care and opportunities (e.g., gyms with equipment & opportunities for people of all sizes; medical facilities that do not weigh patients).

- Trust also the well-informed decision made by an adult who is not interested in health improving behaviors.

- Understand that weight is not behavior. In healthcare settings, focus on behaviors that have direct and measurable health benefits, such as exercise, eating in a balanced manner, stress management, sleep, smoking cessation, moderate alcohol consumption.

Weight Inclusive Approach

- Decouple food from morals. Understand that all foods fit and that pleasure is part of eating. Work with individuals to help them develop goals that are in line with their values for health. What about health is important to that person? Then help develop goals to support that.

- Promote mindful movement if the potential benefits from movement and exercise are important to a person. Regardless of BMI, mortality indicators improve with exercise, indicating that movement can be healthy without a goal of losing weight.

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Assessing Ourselves

- What biases do you have towards people who have larger bodies? What types of conversations do you have with your family, friends and colleagues about body size, dieting, or what being healthy looks or acts like? (see Project Implicit)
- If you live in a thin body, consider the privileges this brings. Keep in mind intersectionality, and how other identities such as race and ability may play a role in the oppression of bodies. How can you be a better advocate for people in oppressed bodies?
- Do you apologize for eating certain foods or in a certain way? Do you feel the need to rationalize eating a large meal?
- What language do you use? The term "obesity" is extremely stigmatizing. Instead, use terms such as "people in larger bodies." Or the word “fat.”
- Language around being fat is one of the last places where society has failed to implement people first language. Not “obese person” but “person in a larger body.”
- As a provider, do you frame goals as related to weight?

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Safety

"If we want to prevent eating disorders we have to make it safe to be Fat".

Dr. Deb Burgard

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True Stories

- 25-year-old man with Anorexia Nervosa. Went from 230 lbs to 150 lbs. Diagnosis missed.
- Late 40s woman who exercises 5 days a week, eats well/regularly/variety. Going through menopause and gained 15 to 20 lbs. Very fatigued.
- “You Don’t Look Anorexic” New York Times article (see link in handouts)

What are your true stories?

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Resources

- Access Project Implicit: https://www.obesitycompetencies.gwu.edu/article/388
- Association for Size Diversity and Health- https://asdah.org/
- Dances with Fat- https://danceswithfat.org/blog/

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**This is the last session in the series,
we hope you've learned and enjoyed it!**

Thank you for attending!

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