

Why Weight? Science, Stigma, Health, Social Justice & Ethics

September 14, 2018

NASW-MO

Jefferson City MO

Confirmation Bias

- The tendency to embrace information we agree with and reject information that challenges our beliefs
- Reflection of the influence of desire on our beliefs
- What do we *want* to be true?

Anorexia Nervosa 307.1

- Persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health) .
- Either an intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain (even though significantly low weight).
- Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Subtypes: Restricting type Binge-eating/purging type

Bulimia Nervosa 307.51

- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
 - Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
 - A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).
- Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise.
- The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for three months.
- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Pica

Rumination Disorder

Avoidant/Restrictive Food Intake Disorder (ARFID)

Other Specified Feeding or Eating Disorder (OSFED)

Almost but not quite meets the criteria, but causes clinically significant distress and impairment in areas of functioning

Unspecified Feeding or Eating Disorder (UFED)

OSFED includes: Atypical anorexia nervosa: All of the criteria for anorexia nervosa are met, except that despite significant weight loss, the individual's weight is within or above the normal range.

Binge Eating Disorder 307.51

- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
 - Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
 - A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).
- The binge eating episodes are associated with three or more of the following:
 - eating much more rapidly than normal
 - eating until feeling uncomfortably full
 - eating large amounts of food when not feeling physically hungry
 - eating alone because of feeling embarrassed by how much one is eating
 - feeling disgusted with oneself, depressed or very guilty afterward
- Marked distress regarding binge eating is present
- Binge eating occurs, on average, at least once a week for three months
- Binge eating not associated with the recurrent use of inappropriate compensatory behaviors as in Bulimia Nervosa and does not occur exclusively during the course of Bulimia Nervosa, or Anorexia Nervosa methods to compensate for overeating, such as self-induced vomiting.

They are all
“Disorders of the
Pursuit of Weight
Loss”

Severe disturbances in eating behavior and consistent disruption of decision-making based on bodily cues of hunger and satiety that are usually the result of the pursuit of weight loss. Once these practices are initiated, the compensatory mechanisms of the body's attempt to regulate weight become part of a vicious cycle that either intensifies or collapses, leaving the affected person with certain reliable sequelae.

A. Any or all of the following:

- B. One or more of the above is/are accompanied by at least three of the four below:

- In addition, code the *frequency* of A/B/C in days per week for the last three months, and whether the frequency is increasing, decreasing, stable, or cyclic.

Obtain a full history of the symptoms and a weight history. On Axis III, note nutritional deficiencies and medical consequences. On Axis IV, note impact on interpersonal and school/work functioning.

Myths

- Weight is determined by “calories in, calories out”
- Weight is controllable
- Weight is a measure of health
- Health can be improved with weight loss

Evaluating Research

- Length of study
- Size and retention of participant group
- Definition of “success” and “significance”
- Unexamined bias

Evaluating Research cont.

- Informed consent
- Conflicts of interest
- Correlation vs. Causation
- “Show me the data!”

Determinants of weight: Genetics

- Adoption study, Stunkard, et al., 1986
- “Set point” Bennet & Gurin, 1984

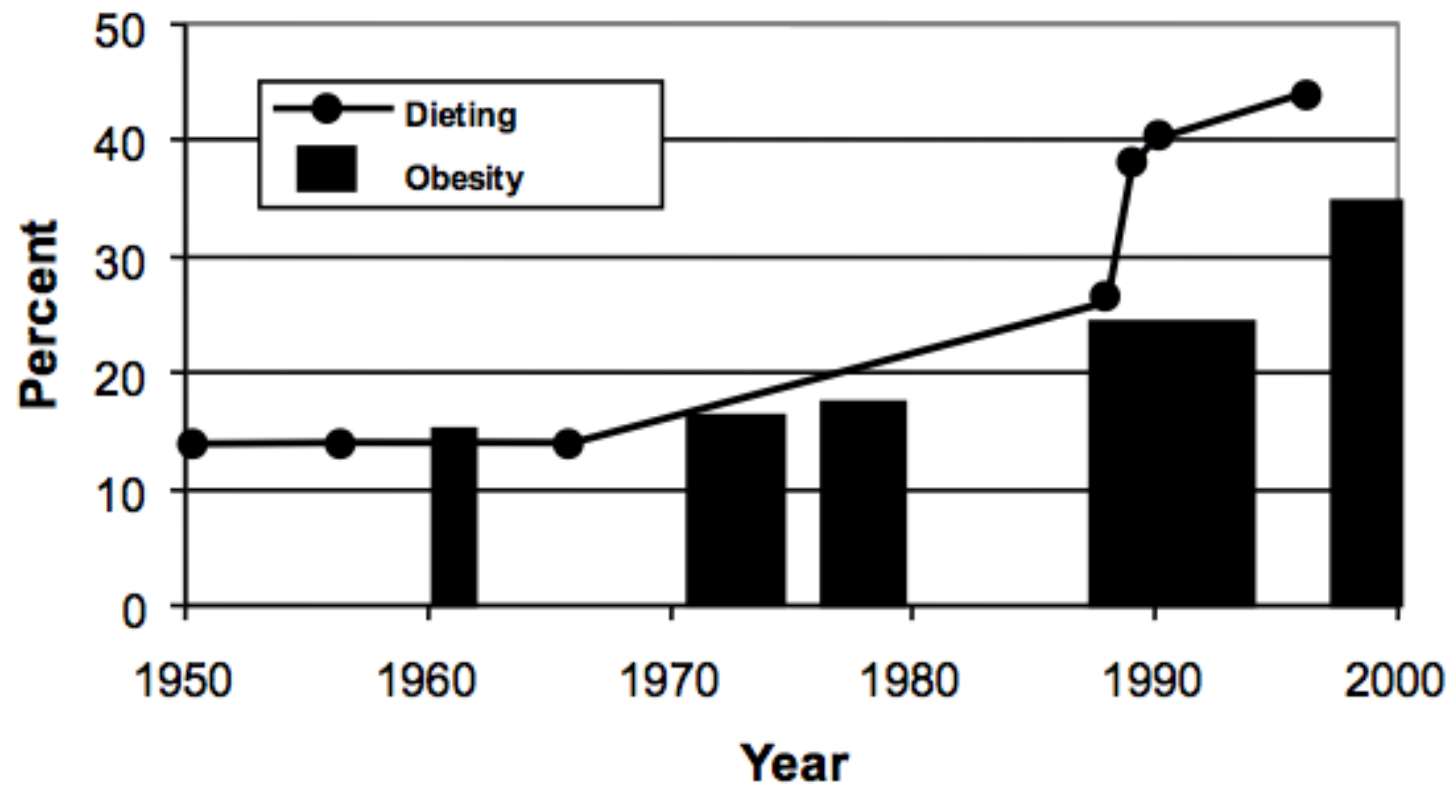
Determinants of weight: Behaviors

- Biological adaptations to maintain setpoint when intake is restricted (Garner & Wooley, 1991; Leibel, et al., 1995; Macpherson-Sánchez, 2015; Ochner, et al., 2015; Sumithran, et al., 2011)
- Psychological adaptations include increased hunger, hyper vigilance concerning food (Keyes, 1950)

Attempts to change the energy balance

- Restricted intake
- Increased exercise
- “Lifestyle changes”
- Dieting can be defined as a voluntary, self-imposed famine (Macpherson-Sánchez, 2015)

We're losing the war anyway



Bacon et al., Intl J of Obesity, 26:854-865, 2002.

Weight and Health

- Always-thin people are not comparable to previously-fat people
- No clear relationship between health and weight loss (Tomiya, et al., 2013)
- Mortality rates lowest for BMI 25-30 “overweight” (Flegal, et al., 2013)
- “Normal weight” acute coronary syndrome patients had highest mortality rate (Angeras et al., 2013)
- Stigma and discrimination play a role (Ernsberger, 2009; Lillis, et al., 2011; Schafer & Ferraro, 2011; Sutin, et al., 2014; Sutin, et al., 2015)

Weight and Health continued

- Psychological distress and body dissatisfaction are associated with higher metabolic abnormalities (Becofsky, et al., 2015; Raikkonen, et al., 2002; Wirth, et al., 2014; Wirth, et al., 2015)
- Cardiorespiratory fitness is a better indicator of health (Barry, et al., 2013; Blair & La Monte, 2006)

Tomiyama, J., Hunger, J., Nguyen-Cuu, J., & Wells, C. (2016). Misclassification of cardiometabolic health when using body mass index categories in NHANES 2005–2012. *International Journal of Obesity*, 1-4.

- 30% of “normal weight” had metabolic abnormalities
- 47% of “overweight” were cardiometabolically healthy
- 29% of “obese type 1” were cardiometabolically healthy
- 16% of “obese type 2 and 3” were cardiometabolically healthy

Unintended Consequences

- Restrictive eating for weight control is a robust predictor of weight gain (Bacon & Aphramor, 2011; Bacon, et al., 2005; Dulloo, et al., 2015; Kater, 2010; Mann, et al., 2007; Siahpush et al., 2015; Tsai & Wadden, 2005).
- Also linked to depression, disordered eating (including binge eating), increased blood pressure, impaired insulin response, increased mortality, reduced self-esteem, and poor health behaviors (O'Hara & Gregg, 2006; Pietiläinen, et al., 2012; Spear, 2006; Tribole, 2012).

Unintended Consequences cont.

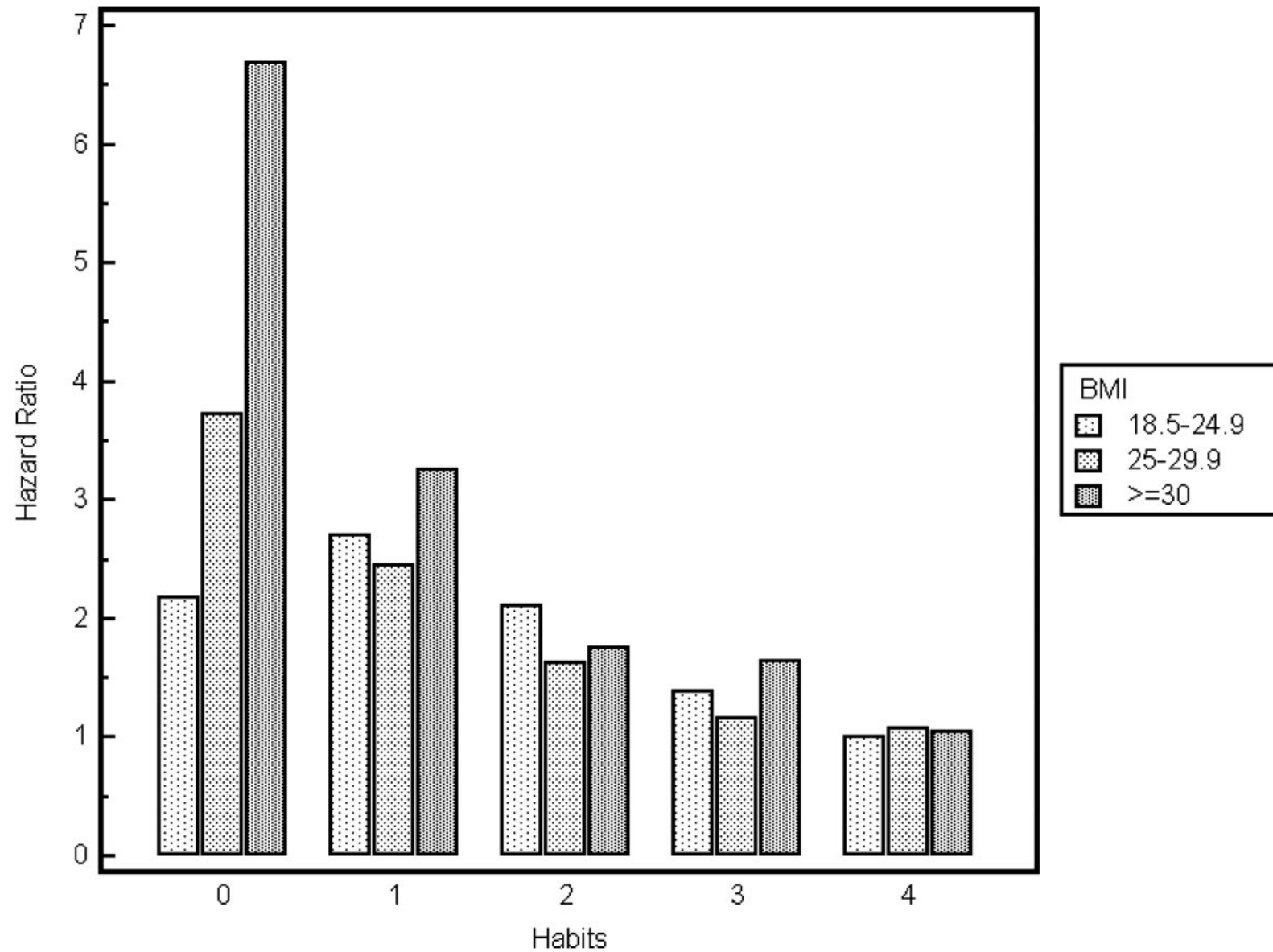
- Body dissatisfaction, regardless of size, is associated with poorer health and health behaviors (Bacon & Aphramor, 2011; Muennig, 2008; Saguy, 2013)
- Unexamined assumptions affect medical care (Amy, et al., 2006; Aphramor, 2012; deShazo, et al., 2015; Puhl & Brownell, 2006)

Weight stigma and psychosocial distress

- ‘When both the prevalence of BD (body dissatisfaction)_and the degree of associated impairment are considered, it is apparent that there is a very substantial public health burden of BD at the population level. Hence, the present findings suggest that greater attention may need to be given to BD as a public health problem in its own right... An additional implication of the present findings is that the fact that dissatisfaction with weight or shape is “normative” in industrialized nations should not be taken to infer that it is benign.’ (Mond, et al., 2013 p. 6)

Weight Neutral Interventions

- Better outcomes regarding health behaviors, physiological measures, psychological outcomes, self-esteem, eating behaviors and participant retention (Bacon, et al., 2005; Bacon & Aphramor, 2011; Blake, et al., 2013; Eisenberg, et al., 2013; Kater, et al., 2002; Kelly, et al., 2002; Neumark-Sztainer, 2009; Neumark-Sztainer, Paxton, Hannan, Haines & Story, 2006; Neumark-Sztainer, Wall, Guo, Story, Haines & Eisenberg, 2006; Sonnevile, et al., 2012; Tylka, et al., 2014)



Hazard ratio for all-cause mortality by body mass index (kg/m²) and number of healthy habits (i.e., fruits and vegetable intake, tobacco, exercise, alcohol). (Matheson, et. al., 2012.)

Follow the Money

- Weight Cycling Industry
- Pharmaceuticals
- Advertising
- Editorial control
- Research funding and publication

Stealing Our Self Esteem To Sell It Back To Us

- Shame
- Disordered eating
- Body dissatisfaction
- Poorer health behaviors
- Increased anxiety in people of all sizes

Medvedyuk, S., Ali, A., Raphael, D. (2017). Ideology, obesity and the social determinants of health: a critical analysis of the obesity and health relationship. *Critical Public Health*, 1-13.

- “The health effects of obesity are overstated”
- “The emphasis on behavioural remedies set the stage for continued stigmatization and victim blaming when weight reduction regimens fail.”
- The effect of weight on health outcomes is minimal when controlling for SDH such as social class, gender or race.

Medvedyuk cont.

- Anti-obesity perspective distracts from SDH and public policy
- Anti-obesity perspective stigmatizes individuals, promoting attitudes that threaten, rather than promote health
- “The balance sheet is clear. Since the anti-obesity perspective does more harm than good, it should be ended.”

Mann, T., Tomiyama, A., Westling, E., Lew, A., Samuels, B., & Chatman, J. (2007). Medicare's search for effective obesity treatments: diets are not the answer. *The American Psychologist*, 62(3), 220-233.

- Criteria for evidenced based treatment
- Seven studies with control group and at least a two year follow up; 14 observational studies with at least four year follow up; Ten prospective studies with four year follow up
- Found multiple methodological problems

Mann et al., cont.

- Weight loss was not maintained long term; claims of health improvement were inconsistent
- Potential harms of weight cycling are considerable
- “The benefits of dieting are simply too small and the potential harms of dieting are too large for it to be recommended as a safe and effective treatment for obesity.”

Tylka, T., Annunziato, R., Burgard, D., Danielsdottir, S., Shuman, E., & Calogero, R. (2014). The weight-inclusive versus weight-normative approach to health: Evaluating the evidence for prioritizing well-being over weight loss. *Journal of Obesity*, 1-18.

- Focus on weight is associated with adverse physical and psychological outcomes
- Dieting is linked to preventable barriers to health
- The weight normative approach is linked to increased shame, blame, stigma, and decreased well-being
- “The weight normative approach becomes a self-perpetuated dogma”

Tylka, et al., cont.

- Body loathing and shame results in decreased self care; people are more likely to engage in good self care when they feel positively toward their bodies
- Weight neutral approaches result in improvement in health behaviors as well as physical and psychological measures
- Weight stigma is associated with increased caloric intake
- Internalized weight bias is not related to BMI
- Public health messages to “maintain a healthy weight” are unfair and uninformed

Dollar, E., Berman, M., & Adachi-Mejia, A. M. (2017). Do No Harm: Moving Beyond Weight Loss to Emphasize Physical Activity at Every Size. *Preventing Chronic Disease, 14*.

- CDC website
- Focusing on healthy behaviors instead of weight loss can decrease stigma, improve health outcomes and strengthen patient-provider relationships
- Acknowledge SDH
- “...that awareness-raising conversations about body weight can do more harm than good.”

Muennig, P., Jia, H., Lee, R., & Lubetkin, E. (2008). I Think Therefore I Am: Perceived Ideal Weight as a Determinant of Health. *American Journal of Public Health, 98*(3), 501-506.

- The assumption that body fat causes health problems is not well supported by the data
- Internal and external stigma cause chronic stress, which is associated with heart disease, hypertension, hypercholesterolemia and diabetes
- The amount of discrepancy between actual and ideal body weight was more predictive of health problems independent of BMI

Oliver, J. E. (2006). The Politics of Pathology: How Obesity Became an Epidemic Disease. *Perspectives in Biology and Medicine*, 49(4), 611-627.

- Largely driven by financial interests
- If obesity is a “disease” then any treatment is subject to insurance reimbursement – from WLS to Weight Watchers to pharmaceuticals
- Weight-loss products are for people who want to look thin, not for health concerns
- The idea that obesity is deadly justifies promoting drugs with dangerous side effects
- “Body weight is an inappropriate focus of concern from both a health and policy standpoint.” (p. 626)

Ethical Concerns

- 1.01 Commitment to clients
- 1.02 Self Determination
- 1.03 Informed consent
- 1.04 Competence
- 1.12 Derogatory language
- 4.02 Discrimination
- 5.02 Evaluation and research
- 6.01 Social welfare
- 6.04 Social and political action

The Health At Every Size® Principles are:

Weight Inclusivity: Accept and respect the inherent diversity of body shapes and sizes and reject the idealizing or pathologizing of specific weights.

Health Enhancement: Support health policies that improve and equalize access to information and services, and personal practices that improve human well-being, including attention to individual physical, economic, social, spiritual, emotional, and other needs.

Respectful Care: Acknowledge our biases, and work to end weight discrimination, weight stigma, and weight bias. Provide information and services from an understanding that socio-economic status, race, gender, sexual orientation, age, and other identities impact weight stigma, and support environments that address these inequities.

Eating for Well-being: Promote flexible, individualized eating based on hunger, satiety, nutritional needs, and pleasure, rather than any externally regulated eating plan focused on weight control.

Life-Enhancing Movement: Support physical activities that allow people of all sizes, abilities, and interests to engage in enjoyable movement, to the degree that they choose.

From <https://www.sizediversityandhealth.org>

What To Do?

- Assessment
- Intervention
- Policy
- Consciousness raising

Self Esteem and Self Determination

- Education
- Internal and external locus of control
- Message about our own worth
- Adequate nutrition is essential

Evaluating Resources

- Is the focus on behavior change or weight loss?
- Does it promise weight loss?
- Does it equate weight loss with improved health?
- Does it encourage decision making based on an internal LOC?
- What is it selling?
- Does it acknowledge social determinants?

Online Resources

- neomsw.com
- Dr. NEO on Facebook
- Association for Size Diversity and Health
- haescommunity.com
- jonrobison.net
- fitwoman.com

Code of Ethics

of the **NATIONAL ASSOCIATION
OF SOCIAL WORKERS**

Jeanne Courtney captured the differences between the HAES paradigm and the WCHP in this reinterpretation of the light bulb joke (Courtney, 2010):

How many weight loss experts does it take to screw in a light bulb? Three. One to stand on the ladder and keep trying to screw a burned out bulb into socket that doesn't fit, one to stand under the ladder and tell him he's doing a great job, and one to write a press release declaring that the three of them have discovered a revolutionary, completely safe and effective new way to screw in light bulbs.

How many Health at Every Size experts does it take to screw in a light bulb? The light bulb is fine, the socket is fine, the switch is on, and the room is brightly lit, but it still takes several dozen Health at Every Size experts, with impeccable academic credentials, to publish independent studies proving that there is no need to change the bulb. And those three guys with the ladder still won't go away.

O'Hara, L., & Taylor, J. (2018). What's Wrong With the 'War on Obesity?' A Narrative Review of the Weight-Centered Health Paradigm and Development of the 3C Framework to Build Critical Competency for a Paradigm Shift. *SAGE Open*, 8(2), 1-28.

Preamble

The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's dual focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.

Social workers promote social justice and social change with and on behalf of clients. "Clients" is used inclusively to refer to individuals, families, groups, organizations, and communities. Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice. These activities may be in the form of direct practice, community organizing, supervision, consultation, administration, advocacy, social and political action, policy development and implementation, education, and research and evaluation. Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems.

Principles

The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective:

- service
- social justice
- dignity and worth of the person
- importance of human relationships
- integrity
- competence.

1.01 Commitment to Clients

Social workers' primary responsibility is **to promote the well-being of clients**. In general, clients' interests are primary. However, social workers' responsibility to the larger society or specific legal obligations may on limited occasions supersede the loyalty owed clients, and clients should be so advised. (Examples include when a social worker is required by law to report that a client has abused a child or has threatened to harm self or others.)

1.02 Self-Determination

Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.

1.03 Informed Consent

(a) Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on **valid informed consent**. Social workers should use clear and understandable language to inform clients of the purpose of the services, **risks** related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions.

1.04 Competence

- (a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.
- (b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.
- (c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm.

1.05 Cultural Competence and Social Diversity

(a) Social workers should **understand culture and its function in human behavior and society**, recognizing the strengths that exist in all cultures.

(b) Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.

(c) Social workers should **obtain education about and seek to understand the nature of social diversity and oppression** with respect to race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, immigration status, and mental or physical disability.

1.12 Derogatory Language

Social workers should not use derogatory language in their written, verbal, or electronic communications to or about clients. Social workers should use accurate and respectful language in all communications to and about clients.

2.03 Interdisciplinary Collaboration

(a) Social workers who are members of an interdisciplinary team should participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the social work profession. Professional and ethical obligations of the interdisciplinary team as a whole and of its individual members should be clearly established.

(b) Social workers for whom a team decision raises **ethical concerns** should attempt to resolve the disagreement through appropriate channels. If the disagreement cannot be resolved, social workers should pursue other avenues to address their concerns consistent with client well-being.

4.01 Competence

(a) Social workers should accept responsibility or employment only on the basis of existing competence or the intention to acquire the necessary competence.

(b) Social workers should strive to become and remain proficient in professional practice and the performance of professional functions. Social workers should critically examine and keep current with emerging knowledge relevant to social work. Social workers should routinely review the professional literature **and participate in continuing education** relevant to social work practice and social work ethics.

(c) Social workers should base practice on recognized knowledge, including **empirically based knowledge**, relevant to social work and social work ethics.

4.02 Discrimination

Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical ability.

5.01 Integrity of the Profession

- (a) Social workers should work toward the maintenance and promotion of high standards of practice.
- (b) Social workers should uphold and advance the values, ethics, knowledge, and mission of the profession. Social workers should protect, enhance, and improve the integrity of the profession **through appropriate study and research, active discussion, and responsible criticism of the profession.**
- (c) Social workers **should contribute time and professional expertise to activities that promote respect for the value, integrity, and competence of the social work profession.**
These activities may include teaching, research, consultation, service, legislative testimony, presentations in the community, and participation in their professional organizations.
- (d) Social workers should contribute to the knowledge base of social work and **share with colleagues their knowledge related to practice, research, and ethics.** Social workers should seek to contribute to the profession's literature and to share their knowledge at professional meetings and conferences.

5.02 Evaluation and Research

(a) Social workers should monitor and evaluate policies, the implementation of programs, and practice interventions.

(b) Social workers should promote and facilitate evaluation and research to contribute to the development of knowledge.

(c) Social workers **should critically examine and keep current with emerging knowledge** relevant to social work and fully use evaluation and research evidence in their professional practice.

6.01 Social Welfare

Social workers should promote the general welfare of society, from local to global levels, and the development of people, their communities, and their environments. Social workers should advocate for living conditions conducive to the fulfillment of basic human needs and should promote social, economic, political, and cultural values and institutions that are compatible with the realization of social justice.

6.02 Public Participation

Social workers should facilitate informed participation by the public **in shaping social policies and institutions.**

6.04 Social and Political Action

(a) Social workers should engage in social and political action that seeks to ensure that all people have equal access to the resources, employment, services, and opportunities they require to meet their basic human needs and to develop fully. Social workers should be aware of the impact of the political arena on practice and should advocate for changes in policy and legislation to improve social conditions to meet basic human needs and promote social justice.

(b) Social workers should act to expand choice and opportunity for all people, with special regard for vulnerable, disadvantaged, oppressed, and exploited people and groups.

(c) Social workers should promote conditions that encourage respect for cultural and social diversity within the United States and globally. Social workers should promote policies and practices that demonstrate respect for difference, support the expansion of cultural knowledge and resources, advocate for programs and institutions that demonstrate cultural competence, and promote policies that safeguard the rights of and **confirm equity and social justice for all people.**

(d) Social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical ability.

Social Justice

- Justice in terms of the distribution of wealth, opportunities, and privileges within a society
- The way in which human rights are manifested in the everyday lives of people at every level of society
- Promoting tolerance, freedom, and equality for all people regardless of race, sex, orientation, national origin, handicap, etc...

NASW definition of Social Justice

- “Social justice is the view that everyone deserves equal economic, political and social rights and opportunities. Social workers aim to open the doors of access and opportunity for everyone, particularly those in greatest need.”
- “Indeed, from the beginning of their profession, social workers have been involved in “connecting the dots” between peace and social justice”

The Social Work Dictionary

- “An ideal condition in which all members of a society have the same basic rights, protection, opportunities, obligations, and social benefits. Implicit in this concept is the notion that historical inequalities should be acknowledged and remedied through specific measures. A key social work value, social justice entails advocacy to confront discrimination, oppression and instructional inequities.” p.405

Stigma

- a mark of disgrace associated with a particular circumstance, quality, or person
- a set of negative and often unfair beliefs
- a strong feeling of disapproval shared by others in society
- An association of disgrace or public disapproval with something, such as an action or condition

Bias

- a tendency to believe that some people, ideas, etc., are better than others
- prejudice in favor of or against one thing, person, or group compared with another, usually in a way considered to be unfair
- a strong inclination of the mind or a preconceived opinion about something or someone

Stereotype

- An exaggerated belief about people based on their membership in a group
- Serves as justification for how they are treated
- Supported by the culture and the media

Prejudice

- preconceived opinion that is not based on reason or actual experience
- an irrational attitude of hostility directed against an individual, a group, a race, or their supposed characteristics
- the Latin *praejudicium* means "judgment in advance."
- Unreasonable dislike or distrust of someone different from you

Discrimination

- Any form of group-based negative treatment
- Preconceived negative judgment based on a person's membership in a certain group
- Other definitions specify that the harmful action is unjustified or represents some form of injustice

Oppression

- prolonged cruel or unjust treatment or control.
- the state of being subject to unjust treatment or control.
- mental pressure or distress.
- unjust or cruel exercise of authority or power
- Social oppression is the socially supported mistreatment and exploitation of a group of individuals. Social oppression is based on power dynamics, and an individual's social location in society

Microaggression

- a subtle but offensive comment or action directed at a minority or other nondominant group that is often unintentional or unconsciously reinforces a stereotype
- behaviors or statements that do not necessarily reflect malicious intent but which nevertheless can inflict insult or injury
- Insults, assaults, invalidations

Weight Stigma

- Internal or external
- Implicit or explicit
- The devaluation of large bodies
- Fatphobia
- Body dissatisfaction
- Anything shaming or oppressing contributes to the problem

Tomiyama, et. al., 2018

“We define weight stigma as the social rejection and devaluation that accrues to those who do not comply with prevailing social norms of adequate body weight and shape.”

Weight Centered Health Paradigm (WCHP)

- Weight normative
- Weight centered
- Weight centric
- Weight conversion
- Weight correction

Health Justice

- Weight neutral
- Weight inclusive
- Health-centric
- A focus on well-being
- Acknowledges social determinants of health

"Health is not a state we owe the world. We are not less valuable, worthy, or loveable because we are not healthy." p. 21

Taylor, S. R. (2018). *The body is not an apology: The power of radical self-love*. Oakland, CA: Berrett-Koehler.

Calogero, R. M., Tylka, T. L., & Mensinger, J. L. (2016). Scientific Weightism: A View of Mainstream Weight Stigma Research Through a Feminist Lens. *Feminist Perspectives on Building a Better Psychological Science of Gender*, 9-28.

- Mainstream weight stigma research is saturated with anti-fat bias and stigmatizing discourses ignoring the lived perspective of fat people
- Discrimination towards fat people is likely to be publicly sanctioned, even when openly hostile
- The scientific literature on weight stigma is a structural form of stigma
- Some researchers believe that encouraging positive body image, which encourages self care, is problem for women who “should” be dieting instead

Calogero, et.al., cont

- ‘Relatedly, public health messages to “maintain a healthy weight” are both uninformed and unfair as they imply that body weight is malleable through sheer will or voluntary action.’ (p. 7)
- The belief that weight is controllable contributes to stigma
- When the literature focuses on the stigmatized target, the stigmatizing agent is invisible and unaccountable

Saleebey, D. (1992). Biology's Challenge to Social Work: Embodying the Person-in-Environment Perspective. *Social Work*, 37(2), 112-118.

- Goodness of fit – what adapts?
- Our knowledge base must be rooted in the reality that biology and society exist in continuing interaction in everyone
- Social workers strive for a more functional integration of mind and body nestled more firmly in social contexts
- We should not become, as helpers, part of the mechanics and metaphors of oppression

“A culture fixated on female thinness is not an obsession about female beauty, but an obsession about female obedience. Dieting is the most potent political sedative in women’s history; a quietly mad population is a tractable one.”

Naomi Wolf, 1990

(media) "has become an economic juggernaut for the structure of global capitalism to generate wealth off our body shame....the global Body-Shame Profit Complex (BSPC)." p. 39

"Body shame flourishes in our world because profit and power depend on it." p. 50

Taylor, S. R. (2018). *The body is not an apology: The power of radical self-love*. Oakland, CA: Berrett-Koehler.

Weight and Income

- Fatness and income are highly correlated
- Poverty may be fattening but a stronger case can be made that fatness is impoverishing
- Fat people are less likely to be hired, are paid less, more harshly disciplined and may be fired for not losing weight

Hartline-Grafton, H. (2011). Food Insecurity and Obesity: Understanding the Connections. Retrieved from <https://www.nbcdi.org/food-insecurity-and-obesity-understanding-connections>

- Limited access to food variety
- Processed, energy dense foods can stretch the budget
- Physical activity is less safe in poor neighborhoods
- Food deprivation leads to overeating and metabolic changes that promote fat storage
- Food insecurity increases stress, which is associated with weight gain
- Low income people have less access to health care

"Our beliefs about bodies disproportionately impact those whose race, gender, sexual orientation, ability, and age deviate from our default notions. The further from the default, the greater the impact. We are all affected - but not equally." p. 51

Taylor, S. R. (2018). *The body is not an apology: The power of radical self-love*. Oakland, CA: Berrett-Koehler.

Mensinger, J. L., Tylka, T. L., & Calamari, M. E. (2018). Mechanisms underlying weight status and healthcare avoidance in women: A study of weight stigma, body-related shame and guilt, and healthcare stress. *Body Image*, 25, 139-147.

- Women with high BMI are less like to seek healthcare than thinner women
- Experienced and internalized weight stigma are related to body-related shame and guilt
- Healthcare stress associated with body-related shame contributes to healthcare avoidance
- Educating healthcare professions about weight bias may improve preventative healthcare in higher weight women

Lee, J. A., & Pausé, C. J. (2016). Stigma in Practice: Barriers to Health for Fat Women. *Frontiers in Psychology*, 7.

- Fat women are less likely to receive screenings for breast and cervical cancer and more likely to die from them
- Fat people are less likely to receive evidence based, bias-free medical care when they do access it
- Weight stigma contributes to eating disorders as well as to the health problems associated with obesity

Tomiyama, A. J., Carr, D., Granberg, E. M., Major, B., Robinson, E., Sutin, A. R., & Brewis, A. (2018). How and why weight stigma drives the obesity ‘epidemic’ and harms health. *BMC Medicine*, 16(1).

- Stigma is linked to poor metabolic and mental health, weight gain, higher cortisol, exercise avoidance, and increased mortality
- Weight stigma is pervasive in health care settings, leading to avoidance of health care
- Anti-obesity efforts contribute to weight stigma
- “Fat-shaming messages encourage discrimination by condoning it.”
- Eradicating weight stigma will improve health for everyone, as people across the BMI spectrum are harmed by it

O'Hara, L., & Taylor, J. (2014). Health at Every Size: A Weight-neutral Approach for Empowerment, Resilience and Peace. *International Journal of Social Work and Human Services Practice*, 2(6), 272-282.

- The weight-centered health paradigm (WCHP) creates an adipophobicogenic environment as well as diminished health and well-being for people of size
- The focus on individual responsibility for health leads to prejudice, bias, stigma and greater social surveillance of bodies
- Given that WCHP is ineffective and harmful, recommending it is unethical
- The Health at Every Size® (HAES)® approach is a strength based, evidence based ethical alternative

The Chief Medical Officer's Ten Tips for Better Health		Alternative Tips
1	Don't smoke. If you can, stop. If you can't, cut down.	Don't be poor. If you are poor, try not to be poor for too long.
2	Follow a balanced diet with plenty of fruit and vegetables.	Don't live in a deprived area. If you do, move.
3	Keep physically active	Don't be disabled or have a disabled child.
4	Manage stress by, for example, talking things through and making time to relax.	Don't work in a stressful low-paid manual job.
5	If you drink alcohol, do so in moderation.	Don't live in damp, low quality housing or be homeless.
6	Cover up in the sun, and protect children from sunburn.	Be able to afford to pay for social activities and annual holidays.
7	Practise safer sex.	Don't be a lone parent.
8	Take up cancer screening opportunities.	Claim all benefits to which you are entitled.
9	Be safe on the roads: follow the Highway Code.	Be able to afford to own a car.
10	Learn the First Aid ABC: airways, breathing and circulation.	Use education as an opportunity to improve your socio-economic position.

Townsend Centre for International Poverty Research

Brene Brown, *Women & Shame*, 2004

- "Shame is the intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging." p. 15
- the result of layered, conflicting and competing expectations based on rigid social and community expectations
- Fundamentalism is "any group espousing a belief system that holds itself so right and true that it discourages or even punishes questioning." p 114

The Nature of Prejudice
Gordon Allport

published 1954
25th Anniversary Edition 1979

“Reference group” vs. “In group”

“In” group is where one belongs, the “we”

“Reference” group is one that is warmly accepted, in which one wishes to be included, aspires to, has obvious advantages

"...you can't advocate for yourself if you won't admit what you are." p 72

"That's why reclaiming fatness - living visibly, declaring "I'm fat and I am not ashamed" - is a social tool so revolutionary, so liberating, it saves lives." p. 113

West, L. (2017). *Shrill*. New York: Hachette Books.

Possible Downsides of Public Health Promotions

- Who makes the policy and why?
- Social determinants of health
- Self determination
- Scare tactics and VFHT (vague future health threats)
- Deliberate use of shame
- Anorexia is framed as a normal consequence

Bombak, A. (2014). Obesity, health at every size, and public health policy. *American Journal of Public Health, 104*(2), 60-67.

- Review of: evidence of metabolic adaptations to resist weight loss; fitness vs. fatness; benefits of weight neutral approaches; and “obesity paradox”
- Public health focus on individual responsibility for weight loss promotes stigma and associated adverse outcomes
- “Obesogenic Environment” is not supported by empirical evidence
- Ethical concerns, including masking discrimination and limiting freedom of choice

Health-ism is a belief system that sees health as the property and responsibility of an individual and ranks the personal pursuit of health above everything else, like world peace or being kind. It ignores the impact of poverty, oppression, war, violence, luck, historical atrocities, abuse and the environment from traffic, pollution to clean water and nuclear contamination and so on. It protects the status quo, leads to victim blaming and privilege, increases health inequities and fosters internalized oppression. Health-ism judges people's human worth according to their health.

Lucy Aphramor PhD, RD

**“THE HEALING POWER OF ANY
PSYCHOTHERAPEUTIC METHOD DEPENDS
ON THE DOSAGE OF ITS BREAK WITH
THE DOMINANT CULTURE” ~MARTIN-BARO**

Dr. Lisa Vallejos

[Lisa Vallejos](#)

April 13 at 2:46pm ·

To [#therapists](#), [#psychologists](#) & [#mentalhealth](#) professionals:

Please stop trying to help [#marginalized](#) & [#oppressed](#) people adjust to an unjust system. By doing so, you are contributing to upholding the status quo.

A social justice oriented view of well being: some ideas

- Acceptance of body diversity rather than eliminating differences
- Acknowledging social determinants when discussing health
- "Well being solution" rather than a weight solution

Some ideas,continued

- Interventions to reduce stigma and discrimination with both individuals and society
- Reframe stigma as discrimination rather than blame
- Focus on changing culture rather than changing bodies

I don't speak to the bully to change
the bully, I speak so those being
bullied can hear

John Pavlovitz, March 17, 2018

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