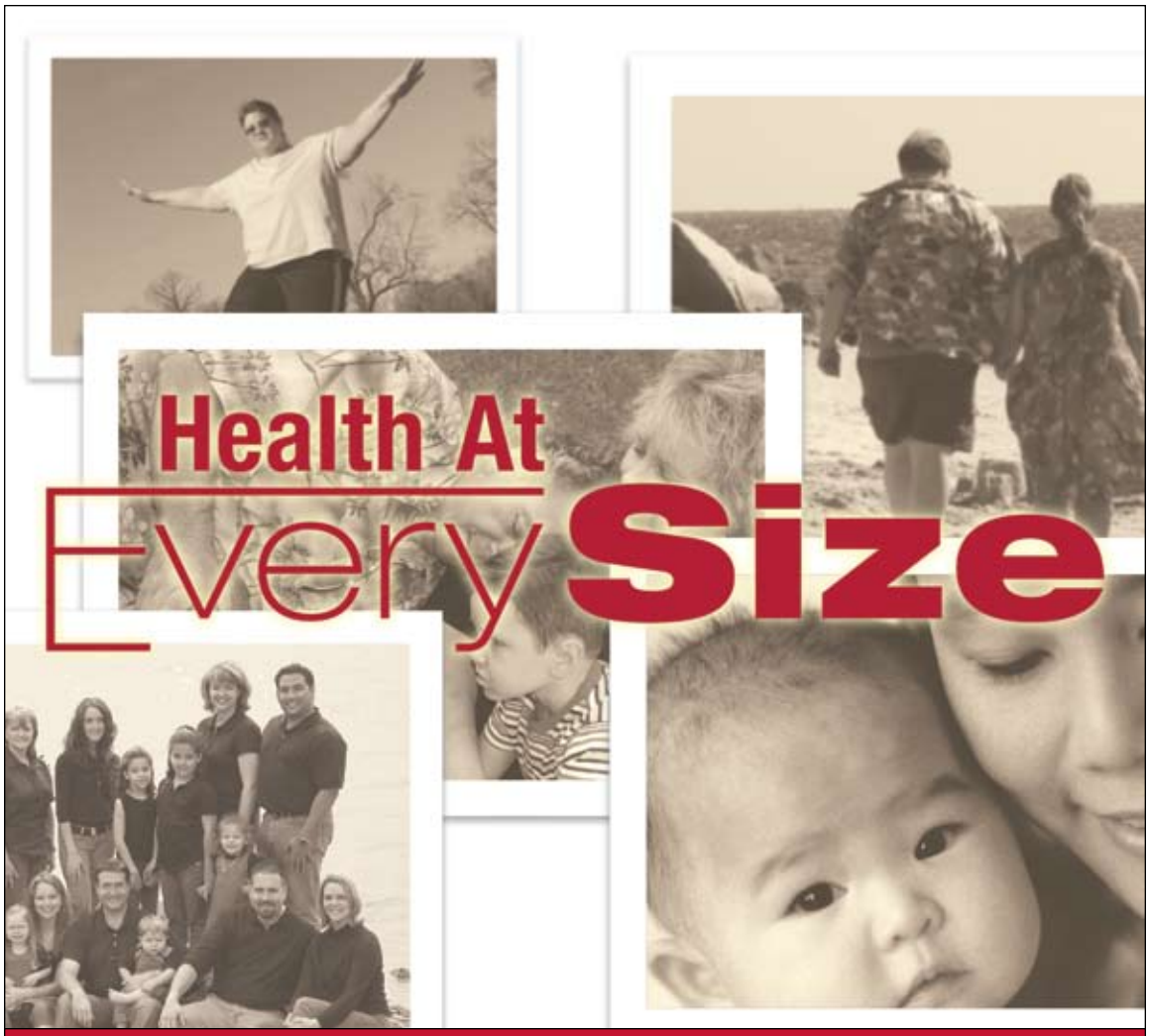
VOLUME 5, NUMBER 3

Absolute ADVANTAGE

THE WORKPLACE WELLNESS MAGAZINE



Special articles on kids including eating therapist, Ellyn Satter, on "What Children Can Teach Us"

IN THIS ISSUE: In the last few years, it seems that the hysteria over the "obesity epidemic" has reached its own "epidemic" proportions. The Surgeon General labeled obesity "the terror within," a terror more dangerous than "weapons of mass destruction," and called for no less than a "cultural transformation" to combat and win the "war" against it. In this issue of Absolute Advantage, Dr. Jon Robison and colleagues present a radically different approach to weight loss and dieting. Known as *Health At Every Size*, this concept is rapidly gaining attention throughout the health and behavior modification communities.

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From The Executive Editors

In this issue of *Absolute Advantage*, Dr. Jon Robison and colleagues address a very different approach to the complex issues related to weight and health. The movement is called *Health At Every Size* and its rapidly gaining popularity.

By acknowledging three core concepts, self-acceptance, pleasurable physical activity and normal eating, *Health At Every Size* looks to provide a superior alternative for helping people with weight-related concerns.

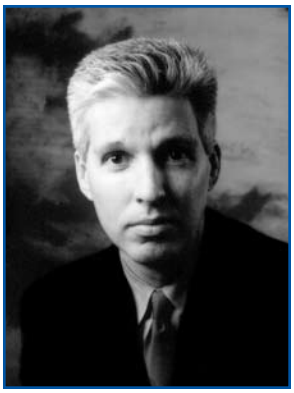
As our invited Executive Editor for this issue, Dr. Robison has called on a number of nationally known and respected leaders. From Ellyn Satter to Glenn Gaesser to Marilyn Wann to Connie Sobczak to Kathy Kater to Kelly Putnam, Dr. Robison has assembled an articulate, qualified and passionate group of authors who share their expertise on promoting *Health At Every Size*.

To be clear up-front, some of the things that you will read in this edition of *Absolute Advantage* will challenge your beliefs and present practices surrounding weight loss and dieting. As with any new approach, thoughtful dialogue and personal examination will be necessary. This issue will challenge you on many fronts.

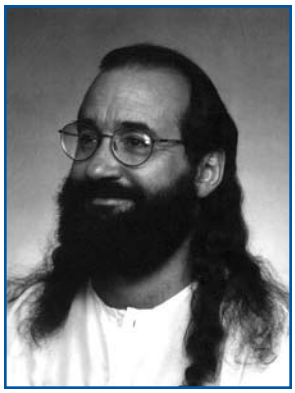
We are grateful to Dr. Robison for his contributions and we look forward to beginning a new dialogue concerning the idea of keeping people healthy at every size.

Yours in good health,

Dr. David Hunnicutt
President, Wellness Councils of America



David Hunnicutt, PhD



Jon Robison, PhD, MS

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Organizational Founder, William Kizer, Sr.

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Absolute Advantage is the interactive workplace wellness magazine that helps large and small employers link health and well-being to business outcomes. ***Absolute Advantage*** arms business leaders and wellness practitioners with leading-edge workplace wellness information straight from the field's most respected business and health experts.

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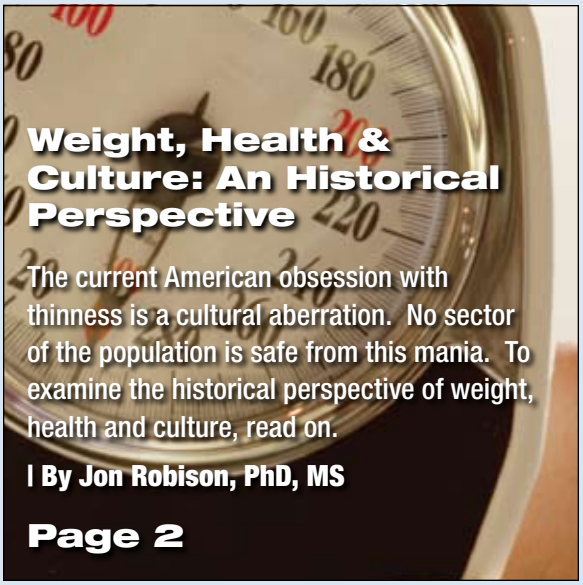

Weight, Health & Culture: An Historical Perspective

The current American obsession with thinness is a cultural aberration. No sector of the population is safe from this mania. To examine the historical perspective of weight, health and culture, read on.

| By Jon Robison, PhD, MS

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WEIGHT, HEALTH & CULTURE

An Historical Perspective

By Jon Robison, PhD, MS

It would be difficult to overstate the urgency that U.S. government and health officials have placed on the dangers posed by obesity. In the last few years, it seems that the hysteria over the "obesity epidemic" has reached its own "epidemic" proportions. The Surgeon General labeled obesity "the terror within," a terror more dangerous than "weapons of mass destruction," and called for no less than a "cultural transformation" to combat and win the "war" against it. In a recent article in the prestigious New England Journal of Medicine, another physician menacingly warned that "the tsunami of childhood obesity has not yet hit shore" and that it was only a matter of time before heart attack and kidney failure became "a relatively common condition of young adulthood."

The impact of this level of rhetoric goes far beyond words and includes: **1) continued biased reporting of research studies purporting causal links between obesity and a wide range of diseases, 2) ongoing pressure for people (particularly women and children) to engage in ineffective and potentially dangerous interventions to lose weight,** and **3) a public that is frightened, anxious and confused about their bodies, their health and their food.**

No sector of the population is safe from the mania. Government agencies are demanding that their workers go on diets and wear pedometers. Schools are banning foods from their cafeterias, eliminating cupcakes for birthday celebrations and including children's body mass indexes (BMIs) on their report cards. Hospital systems all over the country are scrambling to cash in on a skyrocketing demand for organ-mutilating surgeries that are no longer being confined only to adults. Ironically, as in the past, the one result that is least likely to occur from all the heightened hysteria for the vast majority of people is long-term weight reduction.

An American Obsession

The current American obsession with thinness is a cultural aberration. Throughout history, the vast majority of societies have regarded fatness as a sign of success, health, and beauty. This is particularly true for women for whom soft, rounded hips, thighs, and bellies have almost universally been considered ideal.

Even in America, less than one hundred years ago excess body fat was described as a "snug balance in the body bank and a comfortable reserve in the case of emergencies." A 1908 article in *Harpers Bazaar* advised readers on "how to get plump," saying that "fat is force and stored up fat is stored up force." Fashion models were advised to be "far from thin, with no suggestion of hollows in the face or the collar-bones, for the camera seems to accentuate such defects." Physicians regularly encouraged their patients to gain weight, believing that "a large number of fat cells was absolutely necessary to achieve a balanced personality." How times have changed!

Today, in the United States, fatness as chronic disease and weight reduction as cure stand ubiquitously as accepted medical dogma. Anthropologists point out that the first strong cultural emphasis on weight loss appeared around the turn of the century and coincided with women obtaining the right to vote and demanding a more visible and active role in shaping society. As women's power and status improved, the dictates of fashion began to change as well. Medical recommendations for women to lose weight also followed suit. For the next hundred years, medical science would promote a wide variety of potentially dangerous and sometimes lethal diets, drugs, and surgeries to help people reduce their weight "in the name of health." A partial chronological list of these recommended treatments is presented below.[1]

The vast majority of those participating in and suffering from these "cures" would be women, despite the fact that it is well known that women's fat confers only a fraction of the health risk of men's and may actually carry with it significant health benefits. This legacy continues today, as young girls and women continue to divert significant proportions of their physical, emotional and financial resources to the pursuit of ideals of body shape and size that are, for the vast majority, neither achievable nor healthy.

"In The Name Of Health"

1893	Thyroid extract
1920	Laxatives
1933	Dinitrophenol
1937	Amphetamine
1940	Atropine
1940	Digitalis
1946	"Rainbow pill"
1957	Human Chorionic Gonadotropin (from urine of pregnant women)
1964	Total fasting
1969	Intestinal bypass
1974	Jaw wiring
1977	Gastric bypass
1985	Gastric balloon
1990's	Fen-Phen, Redux, Meridia, Xenical, etc.

The "Diet-Pharmaceutical-Industrial Complex"

Since the 1960s, a preference for slenderness has taken hold in other Western, industrialized nations as well as in the United States. However, due to a unique confluence of social, economic, and political developments favoring the desire for thinness, "no other culture suffers from the same wild anxieties about weight, dieting and exercise as we do."[2] The tremendous pressure to be thin is driven by the diet, fashion, cosmetics, fitness, insurance, and pharmaceutical industries, which reap tremendous financial rewards by promoting unattainable expectations, especially for women.

In addition, many obesity researchers have economic links to this so-called diet-pharmaceutical-industrial complex, creating powerful incentives for maintaining the status quo. For example, most members of the National Institutes of Health National Task Force on the Prevention and Treatment of Obesity serve as consultants to both commercial weight loss programs and pharmaceutical companies involved in the development of weight loss medications.[3] As a result,

- **Obesity research is primarily funded by companies that make money by promoting short-term weight-loss methods," contributing, perhaps, to questionable objectivity in the reporting of research findings.[2]**

Traditional Approaches To Weight: The Body As Machine

Traditional approaches to weight management strongly reflect the underlying "man as machine" worldview inherited from the 17th Century Scientific Revolution and embodied in the Biomedical Model of health and disease. Thus, the human body is seen as a "finely calibrated combustion engine that should weigh a certain amount," and therefore scientists have issued "recommendations about exactly how many calories, calibrated to age, height, and activity levels are needed to achieve this goal."[4]

Because body weight has been considered largely a mechanical matter of calories in (diet) and calories out (exercise), weight management is reduced to a measurable numeric equation and it is assumed that everyone can attain their weight goals by merely adjusting these variables. Furthermore, as more and more attention has been paid to trying to determining the exact amount of calories and nutrients needed for optimal health and efficiency, food has increasingly become "an instrument of science, stripped down to a quantity of energy and deprived of all its sensual and emotional aspects."[4]

These premises continue to guide medical weight management efforts. Yet it is common knowledge that weight, like many other human characteristics, varies according to a "normal" distribution, meaning that a wide range of weights occur naturally. Furthermore, the existence of different body types (somatotypes) is well documented,

and it is likely that each has its own range of normally distributed weights and body fat percentages. Dr. William Sheldon, originator of the concept of the somatotype, commented in the 1930s on ideal weights such as those set forth by the height and weight tables, saying "this kind of foolishness gives some of our best people inferiority complexes."[5] Strong arguments have been made that these tables, upon which much of the original hysteria around weight and health were based are flawed to the point of being relatively meaningless for the majority of people. World renowned researcher Dr. Ancel Keys described them as:

> **Arm-chair concoctions starting with questionable assumptions and ending with three sets of standards for 'body frames' which were never measured or even properly defined."[6]**

Today, the most widely used standard for determining what is and is not an acceptable weight is an extension of the weight-tables concept, the BMI or Body Mass Index (calculated as weight in kilograms divided by height in meters squared). Unfortunately, the BMI is fraught with many of the same problems that are associated with the height/weight tables. Although support for its use is often based on the supposed relationship with total body fat, it turns out that BMI is not a good predictor of total body fat in individuals.[7] Furthermore, the BMI does not take into consideration any discrepancies in terms of gender, race, age or ethnicity and it doesn't distinguish between fat and muscle tissue. Given all this, and contrary to popular opinion and government edicts, it should come as no surprise that BMI is also not very predictive of mortality or morbidity for most people, a point which will be explored in more detail in a later article in this issue.

DON'T BE BUFFALOED BY BMI

NAME	BMI	WEIGHT CLASS
George W. Bush	26.3	Overweight
Will Smith	27	Overweight
Yao Ming	27.7	Overweight
George Clooney	29	Overweight
Johnny Depp	29.8	Overweight
Matt LeBlanc	30	Obese
Tom Cruise	31	Obese
Shaquille O'Neil	31.6	Obese
Arnold Schwarzenegger	33	Obese

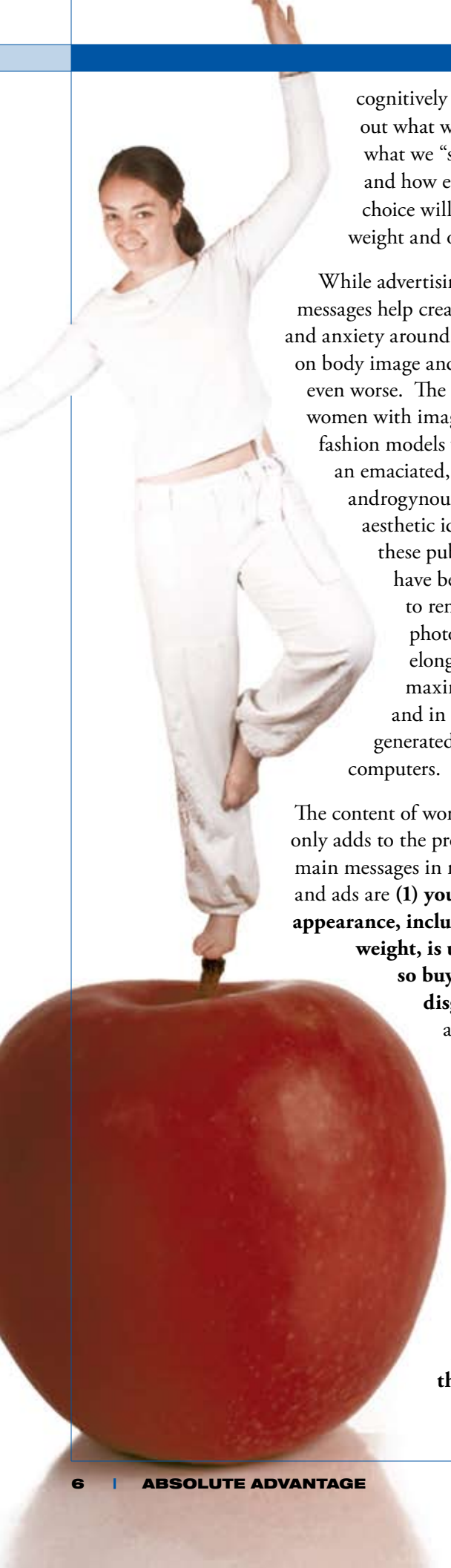
Not only is the BMI as a foundation for determining the relationship between weight and health fraught with problems, the view of weight control as a simple mathematical relationship between caloric intake and expenditure has also been shown to be inaccurate.[8,9] Furthermore, the reduction of food and eating to a matter of calories, devoid of other qualities, denies the reality of the complex interaction of emotional, psychological, and cultural variables that determines voluntary food intake. The resulting "diet mentality" causes people to distrust their bodies which are seen as sources of sabotage. This separation of mind from body inhibits the development of internally regulated eating in children and contributes to the growing incidence of disordered eating in adults.

The Food Industry And The Media

In keeping with the larger cultural agenda, today's media images constantly tell us that we should control our eating and our weight. We have become so accustomed to this phenomenon that we forget it is relatively new. Fifty years ago our grandparents did not walk down grocery store aisles surrounded by thousands of messages about food products being "low fat," "cholesterol free," "low sodium," or "high fiber." Concern about removing "undesirable" ingredients from our diet has led to the conceptualization of foods as "good/healthy" versus "bad/unhealthy." Some health professionals have observed that this has contributed to the development of a problematic food- and eating- based morality. The prestigious *Tufts University Diet and Nutrition Letter* commented on the dangers of this trend over a decade ago, saying:

> **Good nutrition is getting a bad name-one that smacks of rigidity, guilt-making and extremism...Worse still, some eight out of ten [Americans] think foods are inherently good or bad—that is, the decision to eat a particular item has nothing to do with its context in the diet as a whole, but every single bite they take represents an all-or-nothing choice either for or against good health.**

Because our culture encourages us to "think" constantly about our food choices, eating has become an intellectual activity that is increasingly disconnected from the physical body. We no longer know how to eat in response to hunger, fullness, and body cravings because we are



cognitively trying to sort out what we "should" eat, what we "shouldn't" eat, and how each individual choice will affect our weight and our health.

While advertising and cultural messages help create confusion and anxiety around food, the effect on body image and self-esteem is even worse. The media bombard women with images of female fashion models who project an emaciated, adolescent, androgynous look as the aesthetic ideal. Most of these published images have been airbrushed to remove any flaws, photographically elongated to maximize thinness, and in some cases generated entirely on computers.

The content of women's magazines only adds to the problem. The main messages in most articles and ads are **(1) your natural appearance, including your weight, is unacceptable, so buy something to disguise or fix it;** and **(2) "good" women nurture other people by preparing delicious recipes for loved ones, but they do not partake in these rich foods themselves.**

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Not surprisingly, the relentless pressure to conform to unrealistic body shapes and sizes is wreaking havoc with the body image and self-esteem of women of all sizes. A survey in *Psychology Today* questioned more than 3,400 women in their thirties and forties with an average weight of 140 pounds. Among the findings, 24 percent of the women said they would give up more than three years of their lives to lose weight, 35 percent considered pregnancy a major source of body hatred, and 50 percent reported that they smoked cigarettes in order to control their weight. The author of the article concluded that "the magnitude of self-hatred among women is astonishing. Despite being at a weight that most women would envy they are still plagued by feelings of inadequacy."[11] A substantial body of literature supports this extreme body dissatisfaction as a "normative discontent" in our culture, especially among young women.[10,11] Even very young children are not spared. Research indicates that "fear of fat, restricted eating and binge eating are common among girls by age 10."[12]

It is interesting to note that men's health and fitness magazines now routinely feature cover images of young, scantily clad, tan males with washboard abdominal muscles, broad chests, and full heads of hair. Not surprisingly, this new cultural interest in objectifying men has gone hand in hand with an increase in eating disorder rates in this population.[13]

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Efficacy Of Traditional Approaches

The only thing more striking than the universal appeal of traditional approaches to weight management is their similarly universal lack of efficacy. As far back as 1958, pioneer obesity researcher Dr. Albert Stunkard summarized the ineffectiveness of these approaches, stating:

> **Most obese persons will not stay in treatment for obesity. Of those who stay in treatment, most will not lose weight, and of those who do lose weight, most will regain it.**

Yet participation in these approaches continues to grow despite the fact that little has changed to alter the validity of this conclusion, and it is still true that relatively few participants succeed in keeping off weight long term. Perhaps most ironically, with all the recent emphasis on "evidence based" medicine, years of data demonstrating that traditional approaches to weight management do not work and may actually lead to harmful physiological and psychological consequences have not diminished enthusiasm for their continued use among medical and health promotion professionals.

From our homes to our schools to our worksites to our communities, it is essential that we open our eyes to the new data and perspectives on the complex relationship between weight and health. In the articles that follow we will explore the science and philosophy behind and the components and practical applications of an exciting and effective paradigm for helping both children and adults with eating and weight-related struggles. ☆

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ABOUT: Jon Robison, PhD, MS

Jonathan Robison holds a doctorate in health education/exercise physiology and a master of science in human nutrition from Michigan State University where he is assistant professor. Dr. Robison presents frequently at national and international conferences and has authored many articles on health-related topics. His work promotes shifting health promotion away from its traditional, biomedical, control-oriented focus. As co-editor of the journal Health At Every Size - he has been helping people with weight and eating-related concerns for more than 15 years.

Dr. Robison is available for speaking engagements on a wide variety of health-related topics. He is also available to conduct intensive training workshops for groups and organizations that are interesting in learning about and implementing Health At Every Size approaches. You can learn more about Dr. Robison's work by visiting his website at ***www.jonrobison.net*** and he can be contacted via email at ***robisonj@msu.edu***.

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Health At Every Size

Shifting The Focus To Health

The underlying goal of traditional approaches to weight and health is for people to be smaller, i.e., lose weight. As discussed in the previous article, there is little evidence supporting the efficacy of such approaches and mounting concern that they may be violating the primary health care directive of "first do no harm," Furthermore, as will be detailed in a later article in this issue of *Absolute Advantage,* traditional assumptions about the relationship of increased weight to poor health and premature death and the relationship of weight loss to improved health have been seriously questioned in recent years.

Fortunately, there is a compassionate, effective approach for helping people to resolve their eating and weight struggles. The thinking behind this approach first emerged in the 1970's when feminist activists began to expose the way in which women were being targeted differently than men regarding weight and health issues. Then in 1979 two major scientific reviews were published that questioned the effectiveness and social appropriateness of traditional weight loss treatment.[1,2] Since that time, numerous books and articles have been written challenging the basic assumptions of the biomedical emphasis on weight loss. From the combined work of many women and men from a variety of fields, the Non-Diet/Size Acceptance Movement was born. Over the last 30 years this movement has grown in popularity and developed into what is referred to by more and more of those involved as Health At Every Size (HAES).

Health At Every Size

The basic conceptual framework of the Health At Every Size philosophy includes the belief in:

1. **The natural diversity of body shape and size**
2. **The ineffectiveness and dangers of dieting**
3. **The importance of relaxed eating in response to internal body cues**
4. **The critical contribution of social, emotional and spiritual as well as physical factors to health and happiness.**

Table 1 below contrasts the underlying assumptions of traditional weight management approaches with those of Health At Every Size.

Table 1. Comparing The Underlying Assumptions

TRADITIONAL WEIGHT LOSS PARADIGM	HEALTH AT EVERY SIZE
Everyone needs to be thin for good health and happiness.	Thin is not intrinsically healthy and beautiful, nor is fat intrinsically unhealthy and unappealing.
People who are not thin are "overweight" because they have no willpower, eat too much, and don't move enough.	People naturally have different body shapes and sizes and different preferences for food and physical activity.
Everyone can be thin, happy, and healthy by dieting.	Dieting usually leads to weight gain, decreased self-esteem and increased risk for disordered eating. Health and happiness involve a dynamic interaction among mental, social, spiritual, and physical considerations.

What Is A Healthy Weight?

HAES promotes that an appropriate "healthy weight" for an individual cannot be determined by the numbers on a scale or by an ideal height/weight chart or by using the Body Mass Index or body fat percentages. Rather, HAES defines a "healthy weight" as the weight at which a person settles as they move towards a more fulfilling and meaningful lifestyle – a lifestyle that includes eating in an unrestrained manner guided by internal cues and participating in enjoyable, reasonable and sustainable levels of physical activity.

The HAES philosophy does not suggest that all people are currently at a weight that is the healthiest for their circumstances. What it strongly purports is that the movement toward a healthier lifestyle will, over time for most people produce a weight that is healthy for that person. Focusing on weight, as in traditional approaches, is most likely to produce weight cycling and over time, increased weight. Although this conceptualization is often labeled as "radical," it actually is quite congruent with the conclusion statement, over a decade ago, of the National Institutes of Health Consensus Conference on Obesity that:

> **a focus on approaches that can produce health benefits independently of weight loss may be the best way to improve the physical and psychological health of Americans seeking to lose weight.**

It is critical to understand that removing the focus on weight does not imply ignoring health risks and

medical problems. On the contrary, when larger individuals present with medical problems, health professionals should consider and offer the same approaches that they would for a thin person with similar presenting problems. In the case of a thin person with essential hypertension, for example, conventional medicine suggests dietary changes, increases in aerobic physical activity and stress management followed by medication if necessary. Yet a larger individual presenting with the same diagnosis is told to lose weight, despite all that is known about the most likely consequences of this recommendation.

Healthier – At Every Weight

HAES supports a "holistic" view of health that promotes "feeling good about oneself, eating well in a natural, relaxed way, and being comfortably active."[3] Table 2 outlines the major foci for helping people with eating and weight-related struggles from the HAES perspective. These are elaborated on in the text that follows. In all situations, the goal for health professionals is to help people to live healthier, more fulfilled lives by honoring and caring for the bodies they presently have.

Size And Self-Acceptance

The focus on self- and size-acceptance is seen as primary. Body dissatisfaction and hatred are rampant particularly among women of all shapes and sizes in our society. Self-acceptance is an affirmation that, just as human worth is not based on race, color, or creed; it also is not dependent on body weight, shape, or size.

Our obsession with thinness has spawned what may be the last culturally accepted prejudice against individuals who do not measure up to our unrealistic societal standards of body shape and size. The result of this prejudice is widespread social, economic, and educational discrimination against larger individuals.[4,5] As with all forms of prejudice, however, it is not only the persecuted group that suffers. Women of all sizes and increasing numbers of men suffer from the demands of unreasonable expectations that play havoc with their self-esteem and promote disordered eating and exercise behavior.

As a cornerstone of HAES, self-acceptance involves honoring the natural diversity in the human form and challenging cultural weight prejudice. As health professionals we must begin by confronting our own prejudices and learning strategies to empower our clients to do the same. Fortunately, materials have been developed to assist health professionals with the process of understanding and combating their own weight prejudice. These include a number of excellent books written by larger women health professionals who have struggled with the pain of growing up in a thin-obsessed culture.[6,7]

Table 2. Health At Every Size: Major Components

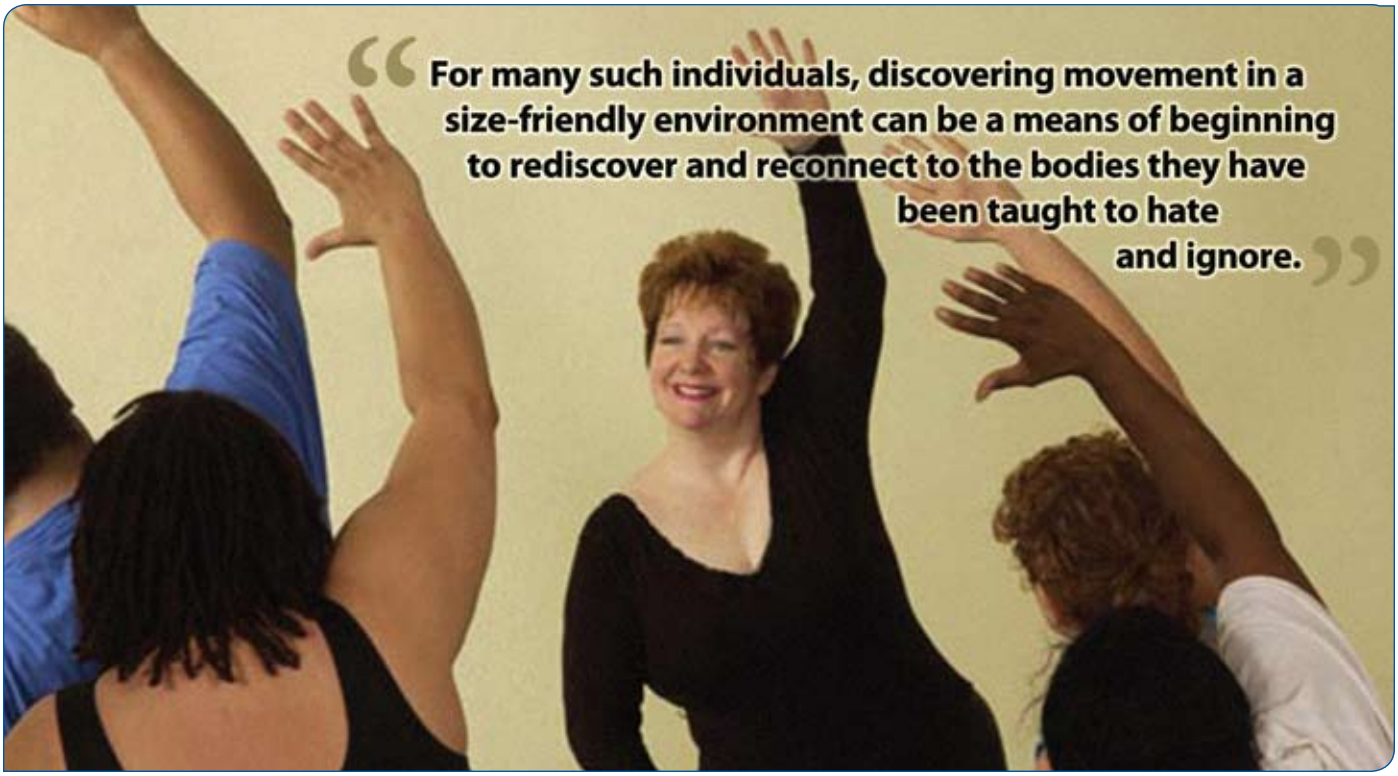
Self-Acceptance Affirmation and reinforcement of human beauty and worth irrespective of differences in weight, physical size and shape.
Physical Activity Support for increasing social, pleasure-based movement for enjoyment and enhanced quality of life.
Normalized Eating Support for discarding externally imposed rules and regimens for eating and attaining a more peaceful relationship with food by relearning to eat in response to physiological hunger and fullness cues.

Physical Activity

Physical activity is widely recognized as an important element in human health, yet the majority of Americans of all sizes remain sedentary. HAES focuses on promoting movement that is social, playful, and pleasurable including not just jogging, cycling, and exercise classes but activities connected with everyday living such as walking and gardening as well. Movement is encouraged for enjoyment, camaraderie, and improved quality of life, not calorie burning and weight loss.

HAES supports physical activity that is reasonable and sustainable. The traditional, structured, sports oriented approach to movement does not work for many people and has likely frightened many more away from being physically active. The emphasis in HAES is on helping people to find movement that is fun and that fits their circumstances.

In addition, this HAES acknowledges the prevalence of sedentary living in our society as largely a cultural phenomenon that cannot be significantly impacted without addressing cultural barriers. This is especially true for larger individuals, many of whom are deterred from engaging in physical activity by fear of the ridicule and



humiliation that they have endured as a regular, ongoing part of their lives.[29] For many such individuals, discovering movement in a size-friendly environment can be a means of beginning to rediscover and reconnect to the bodies they have been taught to hate and ignore.[30]

Normalized Eating

The externally focused, restrictive methods used by diet programs rarely succeed in helping people to become healthy eaters. HAES endorses internally directed "normal," (intuitive, mindful) eating as an important component of "healthy weight" and good health for people of all shapes and sizes. HAES refutes the concept of "good" and "bad" foods and discourages the use of externally-focused eating strategies such as calorie, carbohydrate and fat-gram counting. Instead, all foods are legalized and the focus is placed on reducing anxiety about eating. People relearn how to eat in response to physiological hunger and satiety cues.[8,9] They are taught to listen to and trust their bodily signals as to what, when and how much to eat.

Individuals who adopt normalized eating may or may not see changes in their weight. However, this eating style is likely to improve people's health by reducing the anxiety, guilt, preoccupation with food, bingeing, weight cycling, and weight gain commonly associated with restricted eating (dieting).

HAES recognizes that when people are struggling with food- and weight-related issues it is often symptomatic of underlying distress that cannot be relieved merely by delivering nutrition information and advice. Trying to help people with these kinds of issues while being certain to *do no harm* in the process necessitates a compassionate, truly holistic approach that includes attention to the social, emotional and spiritual as well as physiological aspects of food.

Show Me The Data

Given the tremendous vested interests supporting the status quo with relationship to issues of weight and health it is not surprising that there are many critics of the HAES movement. Critics have particularly pointed to a lack of data supporting the effectiveness of HAES approaches. It is interesting that these same individuals continue to promote traditional approaches in spite of the almost complete lack of research supporting their efficacy and growing indications of negative side effects.

Given a lack of funding support (difficulty finding interest groups to support research that does not include weight loss products, services, etc) there has been only limited research to date directly comparing HAES approaches against traditional programs. Interestingly, however, over the years there have been numerous studies supporting the efficacy of approaches that can improve health

independent of weight change. These studies show conclusively that risk factors traditionally labeled as "weight-related" (elevated blood pressure, cholesterol, glucose, etc.) can be ameliorated and often normalized in people considered to be obese with interventions that have little if any effect on body weight.[10, 11]

Furthermore, in recent papers in the International Journal of Obesity and the Journal Of The American Dietetics Association, researcher Dr. Linda Bacon reported on a long-overdue study comparing the efficacy of an HAES approach with that of a state-of-the-art, traditional, behavioral weight loss intervention. Participants in the HAES and traditional programs obtained the same physiological and psychological benefits over a six-month period. However, almost half of the diet group dropped out, and many of the benefits evaporated over time for the diet group while being maintained by the HAES group.[12,13]

While perhaps surprising to some, these results are precisely what HAES supporters have been predicting for years. The focus on health is effective for helping people to improve their health – the focus on weight is not.

Reshaping The Practice

Health professionals are likely to need some retraining to shift the focus of their work from weight loss to helping people to be healthier at their present weight. This training must incorporate deep introspection regarding personal prejudices and struggles surrounding weight and eating. It should also help practitioners to identify people whose psychological issues make them appropriate referrals for additional support. But it also must include a broadened understanding of how complex socio-cultural issues such as addiction, poverty, abuse, isolation and oppression often underlie people's behavioral struggles. Although this has not been a major part of the traditional training for many health professionals, trying to help people without an understanding of the bigger context of their lives is likely to result in a continued lack of effectiveness and diminished credibility for our professions.

By breaking the endless cycle of weight loss and regain the HAES approach can help stop the waste of valuable resources that results from our cultural obsession with thinness. The goal is to help people improve the quality of their lives regardless of weight status. The end result will be a culture that is less judgmental and more truly diverse and individuals who lead happier, healthier, and more fulfilled lives by honoring and caring for the bodies they already have. ☆

HAES IN PRACTICE: Self-Acceptance

- Avoid admonitions to lose weight
- Positive change comes from self acceptance and self-love not from self-loathing
- Respect for diversity is for everyone
- Very difficult to teach without doing our own work

HAES IN PRACTICE: Physical Activity

- Fat does not necessarily mean unfit
- Do not associate physical activity with weight loss or calorie burning
- Physical activity as "caretaking" - "to move the body not change the body"
- Encourage physical activity not just exercise

HAES IN PRACTICE: Internally Directed Eating

- Listening to appetite, hunger and satiety cues
- Can be relearned by teaching awareness
- No "Good" or "Bad" Foods
- Food nourishes the body, mind and spirit

HAES IN PRACTICE: Health vs. Weight-centered Care

- Avoid size-related assumptions
- Discuss weight and body image concerns with people of all sizes
- Focus on well-being, energy level, lipids, glucose, etc, rather than weight
- Provide concrete reasons not to diet while offering the HAES alternative

HAES IN PRACTICE: Health vs. Weight-centered Outcomes

- Improved quality of life and self-acceptance
- Amelioration of medical problems and decreased reliance on medications
- Increased participation in and pleasure from physical activity
- Increase use of internally-directed eating style and decreased obsession with food

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YOUR CHILD'S WEIGHT

Helping Without Harming

Ellyn Satter, MS, RD, LCSW, BCD

When I was a young dietitian fresh out of graduate school and working in a medical group practice, I was convinced I carried the keys to weight loss for my patients. I had my food lists and my nifty point system for restricting food intake. I even used my point system for children, telling parents what and how much they should let their children eat.

Of hundreds of hopeful weight losers, *two* lost significant amounts of weight and kept it off. Both began as couch potatoes who ate a lot. Both were virgin dieters. They had lots of room for change and they hadn't traumatized themselves—and their bodies—with repeated efforts at weight reduction.

Families provided even more evidence that my system didn't work and, at the same time, gave clues about the adults who had been so unsuccessful with weight loss. On followup, parents reported their child had become a whining food sneak, the siblings spying tattle-tales, and parents police officers. Even children who *wanted* to lose weight sneaked to eat, then felt ashamed of themselves. Despite all the upset, food restriction didn't even *work*. If children lost any weight they gained it back and more besides. In the long run they became fatter, not thinner.

So I went back to the drawing board. Instead of telling parents how to get their child slim, I started from the other end. It is normal for children to eat the amount they need to grow consistently, I reasoned. That being the case, why do some children—and some adults—get fatter than nature intended them to be? I studied lots of individuals and families in detail and read more research papers than I care to think about. The answer was daunting. For the most part, overweight is an iatrogenic condition: It is caused by the cure. In their efforts to do what they had been told was the right thing for their child, parents—and I—were inadvertently contributing to children's weight problems by restricting food intake.

From studying what went wrong with children's eating and weight, I learned the critical importance of doing things right in the first place. The way to prevent overweight, from birth, is to feed and parent well and let each child grow up to get the body that nature intended. In *Your Child's Weight: Helping Without Harming*, I talk about doing things right in the first place. I teach parents to do an excellent job of feeding from the time a child is born until he leaves home. What it all boils down to is this: *Feed and parent well, accept your child's size and shape, and avoid interference.*

Maintain The Division Of Responsibility With Feeding

From my research and clinical experience, I evolved a guiding principle for feeding: The division of responsibility. The parent is responsible for the *what, when* and *where* of *feeding*, the child is responsible for the *how much* and *whether* of *eating*.[1] To feed well, you must make an absolute priority of providing for yourself and your family with food. Family meals and sit-down snacks are key to that providing–and to parenting. Children who have regular family meals do better in all ways: emotionally, socially, academically, nutritionally, with respect to avoiding overweight, drugs, alcohol and early sexual behavior. Family meals are more instrumental in positive outcomes for children than sports, tutors, church, music lessons—the list goes on.[2,3]

Doing an excellent job with feeding your child—throughout his growing-up years—will put you decidedly out of step with what goes on around you. As a society, we are abominable about feeding ourselves, only marginally better about feeding our children, and obsessed with weight. Whether we know it or not, in being so off-hand about eating, we scare ourselves and we scare our children, and that contributes to child overweight. To maintain excellent feeding, you have to discard the norms: being casual and ad-lib about eating, grazing, feeding children rather than eating with them, eating on the run. And you have to do it over the long haul.

Accept Your Child's Normal Size And Shape

My sleuthing led me to the conclusion—now backed up by research—that **the two major causes of child overweight are 1) misinterpreting a child's normal size and shape and labeling it overweight[4] and 2) imposing food restriction.**[5] Every child is born with a genetic blueprint for size and shape and the powerful ability to eat the right amount to support that blueprint.[6] Certainly, some children get heavier than nature intended for them, but some are just naturally heavy. How can you tell the difference? **Weight that plots consistently along a particular percentile on a child's growth chart is normal—even if it is a high percentile.** But weight that accelerates—that crosses upward across growth percentiles—may *not* be normal.[7] If your child's weight accelerates, seek professional help to identify and resolve whatever is causing the weight acceleration. *Your Child's Weight* gives clues to what those causes might be.

"Labeling your child as *overweight* and taking steps to remedy it, whether direct or indirect, make her feel flawed and inferior in *all* ways."

Children slim down as they get older.[8] You can't predict a child's size and shape until she is grown. If you try to force a certain outcome by restricting food intake or forcing activity, you will likely create the very problem you are trying to avoid. Ignore the current alarms about fat babies becoming fat adults. Do an excellent job of feeding, let yourself nurture, then let your baby grow in the way that is right for her. Feed her on demand, start solids when she is ready, and let her join in at the family table when she is about a year old. I discuss optimum feeding in *Your Child's Weight* and in more detail in still another of my books, *Child of Mine; Feeding With Love and Good Sense.*

Keep in mind that chubby infants and toddlers have a 75% likelihood of slimming down as they get older. It isn't until a child is about 13 years old that the odds of remaining heavy pull even with those of slimming down.[9] But even that can change. At around age 13, children plump up just before they stretch up—and slim down—as they go through puberty.

Avoid Food Restriction

We are a society of restrained eaters. Seventy-five percent of adults at any time are restricting food intake to lose or maintain weight.[10] Almost everyone tries to eat less food, and less desirable food, than they really want. A few are able to deprive and keep their weight below what is natural for them. The majority are on the diet merry-go-round, imposing and suspending food restriction on a regular basis—and getting fatter as a result. Even if restrictive eating works for you, it doesn't work for your child. Children are a captive audience. They have to live with what we give them. It frightens them and hurts their feelings if they can't count on our giving them enough. If you are on the diet merry-go-round, so is your child, and studies show he is likely to be fatter as a result.[11]

It is impossible to list all the ways that people restrict their eating, but it helps to consider *intent*. **Are your decisions about food selection *intended* to make your child eat less and weigh less? If the answer is yes, it is restrained feeding, and it is making your child fatter, not thinner.** Also consider your child's eating attitudes and behavior. If your approach to feeding makes him food-preoccupied and prone to overeat when he gets the chance, you are being restrictive.

Be Joyful And Dependable About Choosing Your Food

In *Secrets of Feeding a Healthy Family*, I pointed out that if the joy goes out of eating, nutrition suffers. In that book, which is part expose', part food-management survival guide, I help parents and families rediscover the joy and security of sharing good food. As I pointed out in *Secrets*, cooking and eating can be about the happiness, comfort and passion of celebrating wonderful food, enjoying it with others and leaving the table filled with peace and well-being. Instead, cooking and eating today are too often about applying the rules, about struggling with conflict, shame and deprivation and about trying to forgo pleasure in the name of health.

What is the bottom line with food selection and meal-planning? Choose the foods *you* like and provide family meals that you find rewarding to plan, cook, serve and eat. Even the most reprehensible family meal is better than no meal at all. Meals don't have to be gourmet feasts and you don't to please every family member with every food all the time. Apply the division of responsibility. Being the grownup, you get to choose what to put on the table. Be considerate of your young child's inexperience with food and limited ability to chew and swallow without limiting the menu to foods he will readily accept. Your child's job is to learn to eat the food you eat. Put on four or five different food items and always include bread (family members can eat bread if all else fails). Include "forbidden" foods or your child will sneak them when your back is turned. Don't get pushy—let each person pick and choose from the foods you put on the table. Remember, as far as your child is concerned, your presence and your undivided attention are the most important parts of the meal.

Maintain The Division Of Responsibility With Activity

Children are born loving their bodies, curious about them, inclined to move and driven to be as physically competent as they can possibly be. Good parenting with activity preserves those qualities. Parents provide *structure, safety* and *opportunities*. Children choose *how much* and *whether* to move and the *manner* of moving. Limiting television helps most to encourage increased activity. Even coloring, reading or playing video games are more

active than being mesmerized by the tube. The data isn't in on whether too much screen time in general makes children fat, but managing screen time is still a *parenting* issue. Children who are on the internet too much can get themselves into trouble. Children who get caught in solitary video gaming miss out on socializing and other learning.

As with eating and weight, your having an agenda with activity will undermine your child and your relationship. Even the large child is entitled to like her body and must be trusted to find ways of moving it that are right for her. Resist current attitudes that say, "Well, diet doesn't seem to work to slim children down, but surely activity will." Such attitudes will turn you into a personal trainer rather than a parent, encouraging, cheer-leading, nagging and even coercing your child to *move* in the name of slimness.

Consider Your Whole Child

Chapter 9, of *Your Child's Weight*, "Teach Your Child: Be All You Can Be," encourages you to accept your child the way she is and expect her to be capable. **Labeling your child as *overweight* and taking steps to remedy it, whether direct or indirect, make her feel flawed and inferior in *all* ways.**[12] Instead, help your child develop in ways that *really* matter: Good character, common sense, effective ways of responding to feelings, problem-solving skills, and the ability to get along with others. Children who are relatively fat, like children with other characteristics that make them distinct, need better-than-average social skills in order to succeed.

My audiences and readers—both parents and professionals—ask me, "is that all there is? Surely there is more to it than that." The panic about child overweight makes it seem we should do more—intervene harder—limit eating and push activity—chase an agenda for a child's size and shape. Think about it. How long and how consistently could you supervise your child's eating—in detail—and make sure he eats little enough to be consistently more-or-less hungry? How long can you keep after him to *move*? How much harm would that do? If you need challenge to feel you are doing something, consider the division of responsibility in feeding. That demands roughly 18 years, *per child*, of good parenting with food. That's a *lot*, and it won't be easy.

The division of responsibility in feeding—and parenting—is not for the faint-hearted. ☆

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Fatness, Fitness & Health

A Closer Look At The Evidence

By Glenn A. Gaesser, PhD

Except at true statistical extremes, body mass is a very weak predictor of mortality, especially in older populations. The claim that "overweight" (BMI 25 to 29.9) increases mortality risk at all is not supported by many large-scale studies that have found no increase in relative risk among the so-called "overweight," or have found a lower relative risk for premature mortality among this cohort than among persons of so-called "normal" weight[1]. Among the obese, little or no increase in relative risk for premature mortality is observed until one reaches BMIs in the upper 30s or higher. In other words, **the vast majority of people labeled "overweight" and "obese" according to current definitions do not in fact face any meaningful increased risk for early death.** For example, the most recent comprehensive analysis of this question within the context of the US population found higher death rates associated with a BMI of below 25 than with a BMI above it[2]. This was largely due to the finding that lowest death rates were in the BMI range of 25-29.9—some 86,000 fewer "excess" deaths than the referent group, the so-called "normal weight" BMI range of 18.5 to 24.9. Additional analyses with control for potential confounders as length of follow-up, weight stability, weight loss caused by illness, or smoking status did not change the results. For this nationally representative cohort of U.S. adults—National Health and Nutrition Examination Surveys I, II and III—the "ideal" weight for longevity was "overweight."

These most recent findings from the NHANES data should come as no surprise. Data from NHANES I published in 1998 revealed essentially the same thing—a U-shaped relationship between BMI and mortality[3]. Significantly increased mortality was only associated with the extremes. As noted by the authors, "the resulting empirical findings from each of four race/sex groups, which are representative of the US population, demonstrate a wide range of BMIs consistent with minimum mortality and do not suggest that the optimal BMI is at the lower end of the distribution for any subgroup."

These findings from representative US cohorts are consistent with global observations. A 1996 publication by researchers at the National Center for Health Statistics and Cornell University illustrates perfectly[4]. Researchers at the National Center for Health Statistics, and at Cornell University, scrutinized data from dozens of previously published studies, comprising a total of 356,747 men and 248,501 women—making it one of the most comprehensive analyses of the relationship between body weight and mortality published to date. Among nonsmoking men studied for up to 30 years, the relationship between BMI and mortality was U-shaped, with the lowest mortality rates observed between BMIs of 23 and 29. Thus most of the BMI range that is considered overweight by current U.S. government weight guidelines (BMI 25 to 29.9) was not associated with higher risk. Low BMI, on the other hand, was. And low BMI in this instance does not mean extremely thin. For example, mortality rates for men with BMIs between 19 and 21 (i.e., within the recommended range of U.S. government guidelines) were the same as for men with BMIs between 29 and 31 (i.e., extreme overweight or moderately obese). The researchers remarked, "This quantitative analysis of existing studies revealed increased mortality at moderately low BMI for white men comparable to that observed at extreme overweight, which does not appear to be due to smoking or existing disease. Attention to the health risks of underweight is needed, and body weight recommendations for optimum longevity need to be considered in light of these risks."

As for nonsmoking women, the researchers found no distinct minimum mortality point. The BMI range corresponding to the lowest death rates was quite large, stretching from about 18 all the way to 32. Thus a 5' 4" woman could weigh anywhere from 105 pounds to 185 pounds and have the same risk of premature death. Only beyond a BMI of 32 did the mortality rate begin to increase.

Proof That Fat Can Be "Fit"

The weak association between body mass index and mortality is far from the only problem that besets the claim that overweight and obesity are killers. In most epidemiological studies there are no grounds for making causal inferences between body weight and mortality, particularly because most studies do not control for fitness, exercise, diet, weight cycling, diet drug use, economic status or family health history. Furthermore, in studies that control for some of these factors, the data are usually self-reported and thus of extremely questionable reliability. By contrast, when one or more of these factors is controlled for in a rigorous fashion, the already weak association between higher body mass and greater mortality tends to be greatly attenuated or disappear altogether. The example of fitness illustrates this well. Data on more than 32,000 men and women participating in the Aerobics Center Longitudinal Study indicate that the fittest men and women have the lowest death rates—regardless of what they weigh. In other words, a heavier-than-average person who is physically fit has a better chance of living a long life than does a thin couch potato. In one 1999 report the Cooper Institute researchers focused their attention just on the 21,925 men who had body composition assessments in addition to fitness tests[5]. Men were classified as lean (body fat less than 16.7 percent of total body weight), normal (body fat between 16.7 percent and 25.0 percent), or obese (greater

than 25 percent body fat), and as either fit or unfit—thus allowing for six different categories based on fitness and body composition. Fitness was defined in terms of how long it took each man to reach fatigue during a treadmill exercise test. To be considered "fit" a man only needed to be in the top 80 percent of his age group—a rather generous definition of "fit." For example, this level of fitness could be achieved by taking a brisk walk—about 3 to 4 miles per hour—for approximately 30 minutes four or five days per week. The results confirmed the "fat and fit" hypothesis—and also provided a few other surprising findings.

Obese-fit men had death rates that were just as low as lean-fit men, and, perhaps more importantly, had death rates that were one-half that of lean-unfit men—indicating that fitness is more important than leanness in terms of avoiding premature death. The results were the same whether body fatness was expressed as a percentage of total weight or in terms of actual pounds of body fat. For example, a fit man carrying 50 pounds of body fat had a death rate less than one-half that of an unfit man with only 25 pounds of body fat. Fitness mattered, fatness did not. Neither did leanness, as demonstrated by the somewhat surprising finding that fat-free body mass provided no protection against early mortality. Fat-free, or lean body, mass is the sum of all body tissues other than fat; most fat-free mass is muscle. The highest death rates were observed in unfit men with high amounts of fat-free mass (perhaps former athletes-turned-couch potatoes). By contrast the lowest death rates were observed in fit men with low amounts of fat-free mass. Since muscularity correlates fairly well with fat-free mass, this strongly suggests that merely having a large muscle mass is no guarantee of good health. Data on women enrolled in the Aerobics Center Longitudinal Study also support the fat-and-fit hypothesis[6]. Although data from the Lipid Research Clinics Study indicated that fitness did not entirely eliminate the increased risk associated with obesity, fitness did attenuate the risk[7].

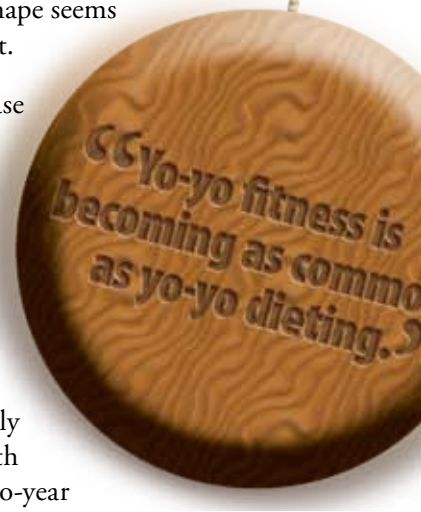
Higher-Than-Average Amount Of Body Fat Is Not Pathological

The claim that adiposity is itself pathological is belied by the results of interventions that remove body fat from their subjects. For instance, a recent study involved removing (by liposuction) an average of nine kilograms (20 pounds) of body fat from 15 very fat female subjects, 8 of whom had diabetes[8]. The study found no improvements in any health markers over the next 10 to 12 weeks, during which time the women were contacted weekly by researchers, to reinforce the importance of not changing their diet or physical activity.

Disentangling the presumed cause-effect link between body fat and "weight-related" health problems is quite straightforward. Exercise and nutrition can effectively reduce blood pressure and blood lipids, and improve insulin sensitivity, effects that are independent of changes in body weight[9-13]. In the Dietary Approaches to Stop Hypertension trial, that involved modest dietary changes (e.g., more fruits, vegetables, low-fat dairy products; less saturated fat) with no weight loss, the reductions in blood pressure among participants with hypertension were comparable to those achieved with pharmacotherapy[10]. Blood lipids can also be improved with changes in exercise and diet, largely independent of changes in body weight or body fat[11].

Improvements in insulin sensitivity and blood lipids as a result of aerobic exercise training have been documented even in persons who actually gained body fat during the intervention[12, 13]. This outcome is entirely inconsistent with prevailing beliefs about body fat and health. It is also important to note that these are not new findings (dating back to 1970). Despite having been available to the scientific community for at least 35 years, these "nonconforming" findings remain essentially ignored.

So too do the data showing that some body fat depots, particularly subcutaneous fat on the hips and thighs, may actually provide significant health benefits[14, 15]. Thigh and hip fat in particular have been reported to be associated with lower plasma triglycerides and higher HDL-cholesterol levels[14]. In the Nurses' Health Study overweight and obese women (BMIs between 25.2 and 48.8) with large hips and small waists had a coronary heart disease risk that was only one-half that of women of about average, or slightly less than average, weight (BMIs between 22.2 and 25.2) who had small hips and large waists[15]. In other words, body shape seems to matter more than body weight.



Just as risk factors for heart disease can be affected by changes in lifestyle independent of changes in body weight, the actual disease itself can be influenced by lifestyle modification—without changes in body weight. The results of the Cholesterol Lowering Atherosclerosis Study illustrate[16]. Eighty-two moderately overweight middle-aged men with heart disease were placed in a two-year intervention program designed to reduce consumption of dietary fat. Men who reduced their fat intake to 27.5% of total calories showed no new fatty deposits in

their coronary vessels (as determined by examination of coronary angiograms taken before and after the two-year study). On the other hand, men who failed to make significant changes in fat intake (34% of total calories from fat) didn't do as well—they all showed some evidence of new lesions in their coronary vessels. Because neither group lost any weight during the two-year study, the researchers concluded that "the appearance of new [coronary artery] lesions can be influenced without weight change by voluntary selection of acceptable foods."

The Roads To Fitness Are Not All That Narrow

It may seem intuitive that exercising more and eating better will naturally result in weight loss. This generally is true, but with a major caveat. Not everyone will lose weight, and it is virtually impossible to tell how much any one person will lose. Most exercise programs and typical diets result in a weight loss of no more than 5-10 pounds; the average "overweight" U.S. adult wants to lose 20-30 pounds! This discrepancy between what Americans want and what exercise and healthy eating are able to deliver highlights the fundamental problem with using weight loss or reductions in body fat to judge the success of an exercise program or nutrition plan. This perhaps explains why dropout rates are so high for traditional weight loss programs. A non-weight-centered approach to health and fitness may provide better results. In fact Bacon et al.[17] recently reported that a non-diet approach was just as effective as a traditional weight-loss program for improving metabolic fitness, with one very important distinction: better adherence (8% dropout rate vs. 41% dropout rate after one year).

Exercise and healthy eating should not be viewed merely as means to an end (weight loss), but rather as having their own intrinsic value. If someone quits an exercise program out of failure to reach a particular weight loss (or reduced body fat) goal, then all the benefits of the exercise are lost as well. And far too many people who start exercise programs don't stay with them. Yo-yo fitness is becoming as common as yo-yo dieting.

In America today millions of men and women (and boys and girls) stigmatized as "too fat" are engaged in a perpetual war with their bodies. It's time we called a truce, and face biological reality. **Some people are naturally meant to be thin, just as some are naturally meant to be fat. Exercise and diet can modify our genetic destiny only so much. The human body is not an infinitely malleable mass of calories that can be burned down to any shape and size desired.** But that doesn't mean we can't all be as fit and healthy as our lifestyle will allow. In terms of health and longevity, the scientific evidence is abundantly clear: It is far more important to be fit than it is to be thin. Contrary to prevailing dogma, the roads to a fitter and healthier body are not all that narrow. ★

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CELEBRATING WEIGHT DIVERSITY

Life's Too Short For Self-Hatred And Celery Sticks!

By Marilyn Wann, MA

When I give presentations on weight diversity, most of the people in the audience have never thought about the number on the bathroom scale without also thinking about some heavy judgments: fat is bad, thin is good. That common device—introduced into our homes less than 100 years ago—doesn't just measure weight. In this culture, it weighs a person's worth: economic, social, and medical.

A sign hanging in Einstein's Princeton office said, "Not everything that counts can be counted, and not everything that can be counted counts." When someone steps onto a scale, they're not primarily measuring weight, they're trying to find out whether they fall on the good side or the bad side of a social dividing line. This hasn't always been true, and it need not be in the future. Our stereotypes and prejudices related to weight confer no advantage, and can do harm. Everything we hope to gain by focusing on weight, we can achieve in a weight-neutral manner, without the poison pill of prejudice. If our goal is for people to be healthy, happy, full participants in the workplace and in society then this arbitrary, harmful, and wholly unnecessary dividing line has to go.

Paying The Cost To Be At A Loss

We pay a high price for a line that purports to be benign, even beneficial. Every year, Americans waste $40 billion on weight-loss products[1] that leave us neither thinner[2, 3, 4] nor healthier, and certainly not happier. What other product can advertise, "Results not typical," and still expect anyone (especially wellness professionals) to buy it? With that enormous investment of money (not to mention time and energy), we could house the country's homeless, we could feed the hungry, or we could put a third of high school graduates through college.

That's just part of the price we pay for dividing and judging people based on weight.

The burdensome effects of weight discrimination are documented in a small but growing body of literature. According to one survey, fat women enjoy nearly $7,000 less in annual household income than thinner women.[5] Landlords are 50 percent less likely to rent to equally qualified fat renters.[6] High school counselors are less likely to encourage fat students to apply for college, colleges are less likely to admit fat applicants, and parents are less likely to pay a fat child's college tuition.[7] According to a National Education Association report, fat children experience "ongoing prejudice, unnoticed discrimination, and almost constant harassment."[8] A handful of fat youth have committed suicide rather than face more bullying. Children as young as five years of age fear gaining weight.[9]

At all sizes, we carry the burden of the fat/thin divide in our daily lives. Eating disorders are popular, and deadly. A disordered relationship to food is standard among young women.[10] In a study on dating, seven times more people responded to a fake personals ad for a drug user than responded to the fake ad for a fat person.[11] Fat women are 20 percent less likely to be married than thinner women; fat men are 11 percent less likely to be married.[12] In the workplace, fat job applicants are told they lack "front-office appearance" or don't fit the "corporate image."[13] In a recent survey of more than 2,000 human resources professionals, 93 percent reported that they would hire a "normal weight" applicant over an obese applicant with the same experience and qualifications.[14] The federal government writes off two thirds of its citizens as "overweight" or "obese," but in fact, no one is safe from weight-based judgment.

Can we really afford to miss out on the full participation—as employees, as customers, as citizens—of at the very least 65 percent of us?

Divide And Bother

Since the fat/thin divide is not an absolute truth but a social construct, the line can get drawn almost anywhere by any of a variety of self-proclaimed authorities. Television shows, movies, magazines, and advertising all draw seemingly indelible fat/thin lines that nonetheless shift with the seasons and trends. Each clothing manufacturer and fashion retailer draws a different line between thin and fat. (Is it size 18? Size 12? Size 8? Hard to tell, since sizes change from vendor to vendor.) Friends and family members and romantic partners help point out that divide, too. Body Mass Index and height/weight charts may seem scientific, but the cutoffs are determined more by the lobbying influence of the weight-loss and diet drug industries than by actual health outcomes. (Remember when millions of people became "overweight" overnight, back in 1998? The government had lowered BMI cutoffs, despite a lack of data supporting any change.) Since these lines can be redrawn at any time, always veering lower, they inspire a general worry.

Learn The Lingo

Overweight:

This word is a judgment in itself! It assumes that in a perfect world, everyone would be thin. Actually, people come in all shapes and sizes—celebrate that diversity! Stop using the O-word.

Obese:

This term medicalizes diversity. Weight is an inaccurate way to predict health. The only thing anyone can diagnose by weighing someone is their own level of weight-based prejudice. What's worse, people who are categorized as "obese" can be denied access to health insurance and needed medical care, while being pressured to undergo dangerous, ineffective "cures."

Large, Chunky, Hefty, Big-boned, Plus-size, Zaftig, Rubenesque, Thick:

These are euphemisms. No matter how well-intentioned or seemingly polite, we only use euphemisms for taboo or unpleasant topics. Break the silence! Use the F-word: ***fat***.

Fat:

This is the simplest word to describe people who are larger than average. It's also the preferred term in the community of out and proud fat people. The F-word is nothing to be afraid of! It holds no negative judgment, unless we put one there. We say young and old, short and tall, why can't we also say thin and fat?

Wherever I speak—whether it's a corporate setting like Macy's or Chevron, an academic conference, a college campus, a teen girl empowerment day, or a gathering of eight-year-old Girl Scouts—I find that we have all learned the same messages about the fat/thin divide. We have 100 percent saturation and 100 percent recall.

During weight diversity presentations, I invite audiences to brainstorm all of the words that our culture currently teaches us to associate with the words fat and thin. I call it an exercise in anthropology. I don't imagine that anyone in the room invented these beliefs or is responsible for them. I promise to do a Happy Dance whenever someone bravely offers a suggestion that breaks our usual politeness bounds, or whenever someone offers a suggestion I haven't heard before. Once people get started, it's like an Easter egg hunt. Whether I'm talking to corporate executives or third graders, people offer the following concepts every single time…

They tell me that our society teaches us to associate the word thin with: healthy, happy, successful, active, disciplined, in-control, rich, smart, popular, attractive, sexy, wearing stylish and tight-fitting clothes, eating lettuce or water, good. Also: toothpick, string bean, beanpole.

They also tell me that our society teaches us to associate the word fat with: stupid, smelly, lazy, ugly, gluttonous, poor, unhealthy, unhappy, depressed, angry, unpopular, out-of-control, a failure/loser, asexual/hypersexed, wearing unfashionable and baggy clothes, eating donuts and junk food, bad. Also: cow, whale, hippo, pig, elephant.

The same negative stereotypes that apply here to fat people have been applied, with pertinent variations, to every outsider group. Prejudice is not an inventive process.

I believe that every one of us is a stakeholder in erasing the fat/thin dividing line because it

has made each one of us feel hurt and angry and sad and less-than at specific moments in our lives and also because it creates a kind of ambient pressure, the alienating extent of which is difficult to gauge since we're surrounded by it. I can attest that during a month-long visit to post-Soviet Russia, despite the daily hassles of being there, the fat/thin line was almost imperceptible and I felt great! I saw no thin-centric TV or movies or magazines or ads. People I met made no negative comparisons about appearance; we had more interesting things to talk about. Retail marketing was a pile of sausages in an otherwise empty shop or a sidewalk sale on watermelons.

Within 10 minutes of landing at Heathrow Airport, a familiar and diminishing pall fell over me again. A glut of shops offered to make me over into someone wholly unlike me, via cosmetics, jewelry, gifts, and clothes in a narrow range of sizes, while magazines kept me informed about the sex lives of ultra-thin celebrities. I imagine each of us will feel healthier and happier and more fully alive, the fainter that dividing line becomes. Whatever one weighs, that line divides one against oneself and makes it difficult to feel at home in one's own skin. Which is a conundrum, because where else is one to go, to live?

7 Steps To Weight Neutrality

Social justice isn't easy, but it's always better than the alternative. Here are the steps I suggest—and encourage!

1. **Imagine that, instead of the fat/thin line being a given and your body needing to change, it's the other way around.** That is the radical shift.
2. **Tap into skepticism.** We can't end the witch hunt on fat people until we're willing to ask, "What's wrong with being a witch?" Get angry about the way things are, it's a wonderful source of energy for making change.
3. **Question the big three lies that attempt to justify the existence of the fat/thin line:**
   1) the belief that weight is a choice
   2) the belief that weight predicts health
   3) the belief that fat is inherently ugly.
4. **Practice being aware of when and how the fat/thin line gets etched deeper.** For example: small talk about others' appearance or food choices (how invasive!); a TV personality wearing a fat suit; blaming any/all undesired aspects of one's life (including health concerns) on one's weight; going along with fat jokes; our own, internal chidings.
5. **Demonstrate weight neutrality.** Instead of going along with thoughts or words or actions that redraw the fat/thin line, find a fun way to erase the line, instead. It can feel daunting to go against the mainstream, but it can also be a big relief. I used to anticipate that people would laugh or tell me I'm wrong when I speak up against weight-based judgments. Instead, I find that people around me—of all sizes—are grateful and also relieved. It's as if we are waiting for someone to admit that the king is naked and the world is round after all.

Simple Ways To Change The World

➤ **What a person is allowed to wear says something about who that person can be.** A fat activist colleague of mine enjoyed competing on the swim team in high school. Then one year, the coach told her the swimsuits didn't come in her size. She didn't jump into a pool again for a decade. If the largest t-shirt a team-building event in a workplace offers is a size XL, it will have a counterproductive effect on people who wear larger sizes.

➤ **End the invisibility.** If space aliens tried to understand human society from our media broadcasts, they would anticipate meeting almost no fat people. When corporate literature shows photographs of the people who work there, that's an opportunity to make all sizes of employee visible. If materials only show thin employees, that sends an inhospitable message. Are fatter people not welcome or valued employees? Likewise for wellness materials: If fat employees see only thin people depicted in brochures, they may reasonably feel excluded from the enjoyment of good health or from making use of wellness resources.

➤ **What do you have to lose?** Make a list of everything that would be lost if you (your workplace, your wellness program, etc.) divest from existing investments in the fat/thin system. Weigh-ins? BMI calculations? Self-criticism? Improbable prerequisites to good health? The hope of wearing a certain size of clothing? This exercise shows how the fat/thin divide involves deficit thinking, while celebrating weight diversity emphasizes assets. In a weight-neutral approach, everyone has access to their own best health, beauty, and respect.

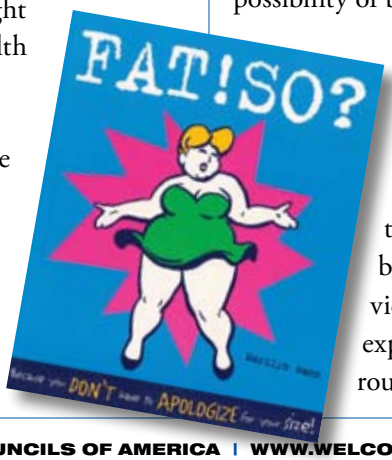
"Body Mass Index and height/weight charts may seem scientific, but the cutoffs are determined more by the lobbying influence of the weight-loss and diet drug industries than by actual health outcomes."

6. **Gather a community of support for weight neutrality.** You aren't alone. We aren't alone! Instead of being isolated from each other, fat against thin, the size eighteens against the size eights, our 18-year-old selves against our current embodiment, in ever-narrower increments, we can join together in celebrating weight diversity, which is, simply, the commonsense understanding that people come in all shapes and sizes. Find people and groups and writing and images that help erase the line. Setting a new standard for social behavior is a group effort, even if we each sometimes move toward that goal on our own.

7. **Be gentle with yourself.** You didn't learn the fat/thin divide in a day. Being weight neutral is an ongoing practice, but the rewards start right away.

The Velveteen Habit: Making It Real

I've been practicing weight neutrality since 1993, when I had my *Really Bad Day*. One evening, I was having dinner with a male friend who confessed that he was embarrassed to introduce me to some of his friends because I was fat. Stunned and hurt, I went home, opened my mail, and found that Blue Cross of California had denied me the right to buy individual health insurance due to my "morbid obesity." Because of that double whammy, I decided to come out as a fat person. (I had learned, as poet/activist Audre Lorde says, "Your silence will not protect you.") I published a small 'zine called *FAT!SO?* and then wrote the *FAT!SO?* book. During this time, I learned about the suicides of Brian Head, Samuel Graham, and Kelly Yeomans, fat teens who saw no end or hope as alternative to weight-related bullying. Because of their stories and my feeling of responsibility to offer whatever I can to prevent further tragedies, I started going to high school classrooms and talking about the fat/thin divide and how we can all help erase it. I imagined that I'd be laughed at, as I was on occasion on the playgrounds growing up. Instead, I found eager listeners. I realized, repeatedly, that I could not predict, based on appearance, whether—and how—people were suffering from that dividing line. I've found that working to erase the fat/thin line—even when that work is daunting, exhausting, disheartening—is a million times better than my life ever was while I was living under its authority.



Now it's your turn: Instead of living according to the limits of the fat=bad/thin=good, bathroom scale binarism, I invite you to acknowledge and celebrate the diversity of all of our weights. I'm excited simply to offer this third option, which I couldn't conceive of when I was a chubby child, a plump teen, or an "overweight" young woman, the possibility of being fat (or thin) and that not being a big deal. I'm also excited to find out how you'll envision weight diversity. I've pushed the horizons pretty far, but mine is only one viewpoint. There's a lot to explore, and our world is round, remember? ★

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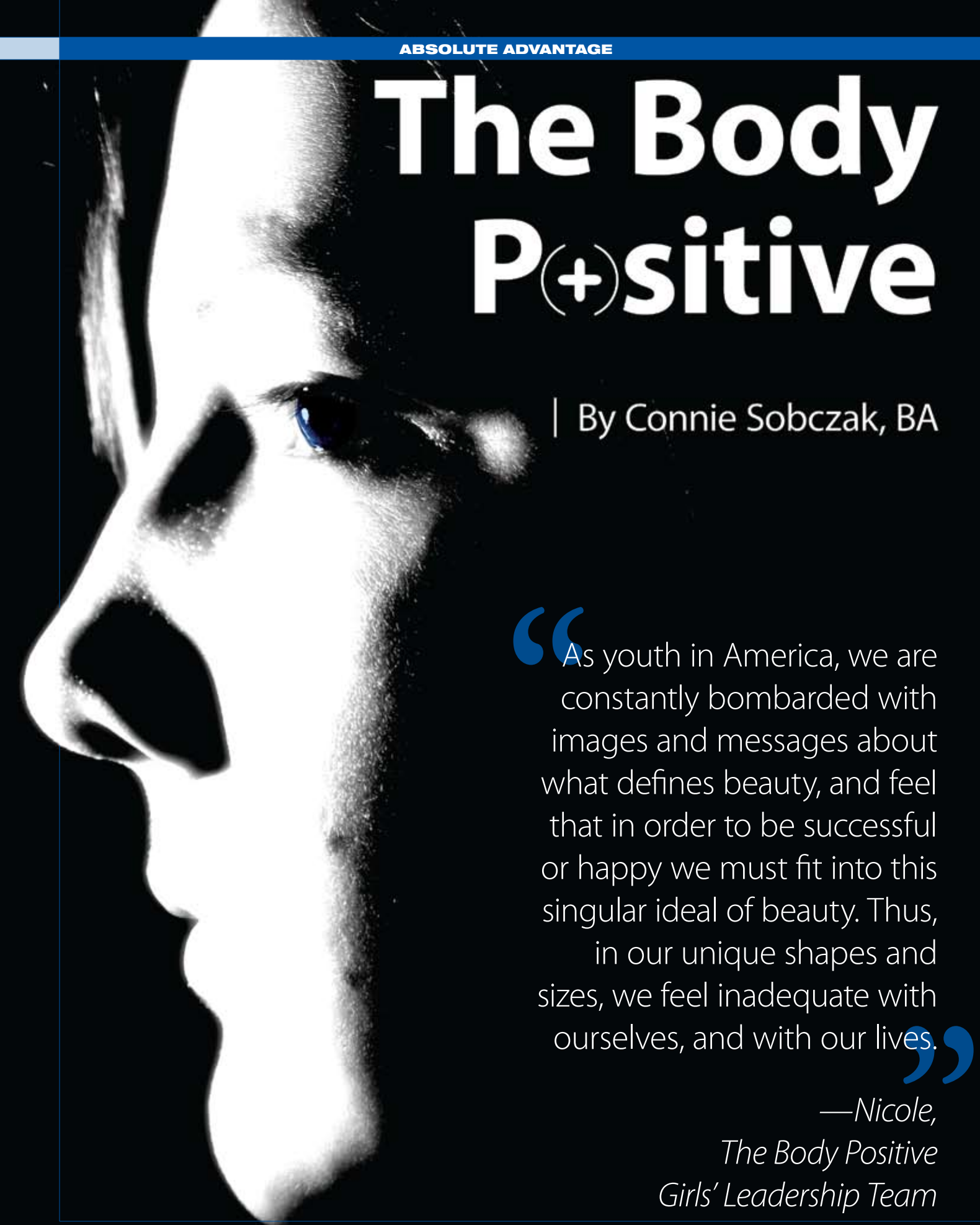
The Body P(+)sitive

| By Connie Sobczak, BA



"As youth in America, we are constantly bombarded with images and messages about what defines beauty, and feel that in order to be successful or happy we must fit into this singular ideal of beauty. Thus, in our unique shapes and sizes, we feel inadequate with ourselves, and with our lives."

—Nicole, The Body Positive Girls' Leadership Team

We have reached a moment in history when body hatred and dieting behaviors are considered a normal part of development for adolescent girls of all ethnic and socioeconomic backgrounds, when more and more boys are using drugs to bulk up their bodies in order to fit a new standard of male beauty, and when children are being put on restricted calorie diets to "do something" about their body size. (1,2,3) The media is in a frenzy over the "obesity crisis." Billions of dollars are being spent by health foundations and government agencies to "combat obesity." The general public is also spending billions of their hard-earned dollars on diet products and services in their fight against fat, even though over 90 percent of the people who go on diets gain the weight back (and often more) within two to five years. (4,5) We live in a nation that is more invested in reducing Body Mass Index (BMI) and caloric intake in children than it is concerned that children are getting eating disorders in ever-growing numbers with younger ages of onset, and that millions of children don't even have enough food to eat on a daily basis to nourish their growing bodies. Has any part of this war on obesity over the past several years been successful in reducing our national waistline permanently? Not even close.

It is time for a change of focus.

- A teenage boy chooses to return home early from a weekend visit to an out-of-town friend because he craves a nutritious meal that includes fresh vegetables, a meal that he can't get at his friend's home.
- A girl enters puberty and loves the flesh on her belly and hips; embraces the process of becoming a woman. She is an American teenage girl who has never known a minute of body dissatisfaction.
- A 15-year-old girl who experiences extreme self-loathing and shame about her body to the point where she will not exercise because she does not want to expose any part of her flesh learns to critically examine how her belief system emerged and becomes a leader among her peers, teaching them that there is an alternative to their self-hatred and diet/binge lifestyles. She enters adulthood with self-esteem, confidence and a healthy active lifestyle, graduates with honors from one of the top women's studies programs in the country, and continues her education in psychology in a French graduate program.
- A high school senior interested in a career in medicine hears a lecture on Health At Every Size and how the war on obesity is harming our nation's children more than helping them, and decides to change her area of focus from plastic surgery to pediatrics.

About The Body Positive

The four anecdotes above are about young people who have been exposed to the philosophy of The Body Positive, a non-profit organization based in Berkeley, California that creatively teaches young people to transform the conditions in their lives that shape their body image and relationship to food. The Body Positive supports the development of youth-driven eating disorders prevention and body image education programs and produces educational videos and materials that promote healthy eating, active lifestyles, and an appreciation for size diversity.

The Body Positive was founded because of our desire to create a world where children can grow up in healthy bodies of all shapes and sizes, and with the highest esteem for their unique selves. Our primary goal is to create educational programs and materials to inspire children and teens to know that they have the power of choice in deciding whether or not to dive into the bizarre and confusing – and potentially harmful – world of bad body image and eating problems. We want youth to know that an alternate reality exists to the one that culture holds up (body perfection) as the road to happiness. We want them to hear real people speak honestly about their struggles and how they resist or reverse the downward spiral of self-hatred to lead vital, creative and fulfilling lives.

Since its inception, The Body Positive has produced a complete series of age-appropriate videos for children and teens ages six to 18. We know that the best way to get our message across to young people is through the voices of their peers, so our videos present only the voices and stories of children and teens. Each of the BodyTalk videos is accompanied by a simple and effective guide to be used to facilitate post-viewing discussion and activities. Our guidebook, *BodyAloud! Helping Children and Teens Find Their Own Solutions to Eating and Body Image Problems*, was written with the input of many of the youth leaders trained by our organization, with the purpose of providing schools and youth organizations with the philosophy and tools needed to develop their own youth-led programs. Over 4,500 videos and books have been distributed in the United States and abroad.

The BodyAloud!

The Body Positive's BodyAloud! program was developed for high schools, middle schools, elementary schools, universities, community-based agencies, hospitals, clinics, youth groups, churches, or wherever young people are found. The program can be easily tailored to fit the specific needs of diverse communities, because participants themselves are asked to identify problems and create their own solutions.

The purpose of the program is to initiate a process of dialogue with students, teachers, school staff, parents and community service providers to address the conditions that increase eating problems in children. These dialogues are for the purpose of identifying strategies to promote a climate of acceptance of diversity in body shape and size, and to allow young people to give voice to their distress. By addressing adverse conditions that affect body image and eating, we can begin to create a safe environment for children of all sizes. It is then possible to promote real health through the principles of the Health At Every Size paradigm.

The Body Aloud! approach is consistent with the World Health Organization's "Health Promoting Schools Framework," which teaches an ecological approach to fostering health in youth through a process of creating dialogue with teachers, students, parents, health providers and community leaders. (6) The goal is to collectively encourage actions to improve the environments that lead to body image and eating problems in youth. It is our goal to provide *all youth* with the opportunity to voice their feelings about the conditions in their lives that cause eating and body image problems, and with the tools and support necessary to invent *their own* solutions to the problems caused by those conditions.

Training and Consultation:

The Body Positive staff train educators, mental health and medical professionals, parents and youth to prevent eating disorders and to promote body esteem by customizing our educational programs for use in diverse communities. We assess the needs of communities and/or schools, and tailor a program based on their desired program scope and commitment level. From teaching people to use our *BodyTalk* videos for classroom presentations, to helping them set up a school-wide comprehensive program with an emphasis on peer leadership, we can address the body image and eating problems of children and teens from diverse backgrounds.

In 2002, The Body Positive's Co-Director Elizabeth Scott, LCSW, trained 40 professionals at the Mental Health Association in Illinois (MHAI) to disseminate the BodyAloud! model to educators and health professionals in 525 Illinois school districts. The MHAI received a grant from the state attorney general to improve the health of Illinois youth, and chose to focus on the prevention of eating problems. They have spent the past three years doing their trainings with great success and very positive feedback. Every school district received, along with the training, a copy of the *BodyAloud!* guidebook and each of the *BodyTalk* videos. The project is in its final stages, and will culminate in 2006 with a statewide conference where Elizabeth Scott will be featured as keynote speaker. The Illinois program is an excellent example of what can be done with The Body Positive materials and expertise. We applaud their efforts to improve the health of their state's youth.

Changing Perspective:

I once spoke by phone to a young bulimic woman who was struggling to recover. She was sitting in her apartment with a plate of brownies and a bowl of green beans. "I know I should eat the green beans and throw away the brownies," she said, "but I don't think I have the strength to do so." I mentioned to her that there was a choice other than being "good" by eating the green beans and getting rid of the brownies, or "bad" by eating the brownies and ignoring the beans. There was the option of eating some of both foods; eating enough of each until she felt satisfied. She was stunned. In her black and white world she had the choices of good or bad. There was no other option. And in her world, being bad meant vomiting out her badness, regardless of the risk of death or coma due to heart failure.

> *Denial of needs and desires leads to craving leads to bingeing leads to guilt leads to deprivation leads to craving leads to bingeing leads to guilt leads to deprivation leads to…*

This young woman lives in a society that thinks in terms of black and white. Fat is bad and thin is good. There are no other options because that is what the "experts" tell us and we must believe what we are told, despite evidence to the contrary that proves that people can be healthy in a wide variety of sizes and shapes.

The good news, as the articles in this issue of Absolute Advantage clearly demonstrate, is that the research emphatically supports the efficacy of lifestyle changes irregardless of weight loss for creating real, long-lasting health. The foundation of The Body Positive's work is to help people of all ages understand the benefits of living a Health At Every Size lifestyle that is free from dieting and deprivation, and encourages eating a wide variety of foods, pleasurable and regular physical activity, and the honoring and expression of Self in our genetically inherited bodies.

Key components in helping children and teens achieve real health, confidence and self-love that lasts a lifetime:

- Our nation's children need the adults in their lives to get off the weight loss merry-go-round and to see the pain and suffering they are causing because of their outmoded beliefs about fat. Mothers and fathers and teachers and health professionals and child care providers need to start listening to the words they say about their own bodies in front of children, and to the direct comments they make to the children in their lives. We must be the very best role models that we can be, modeling love for our own flawed yet perfect selves.

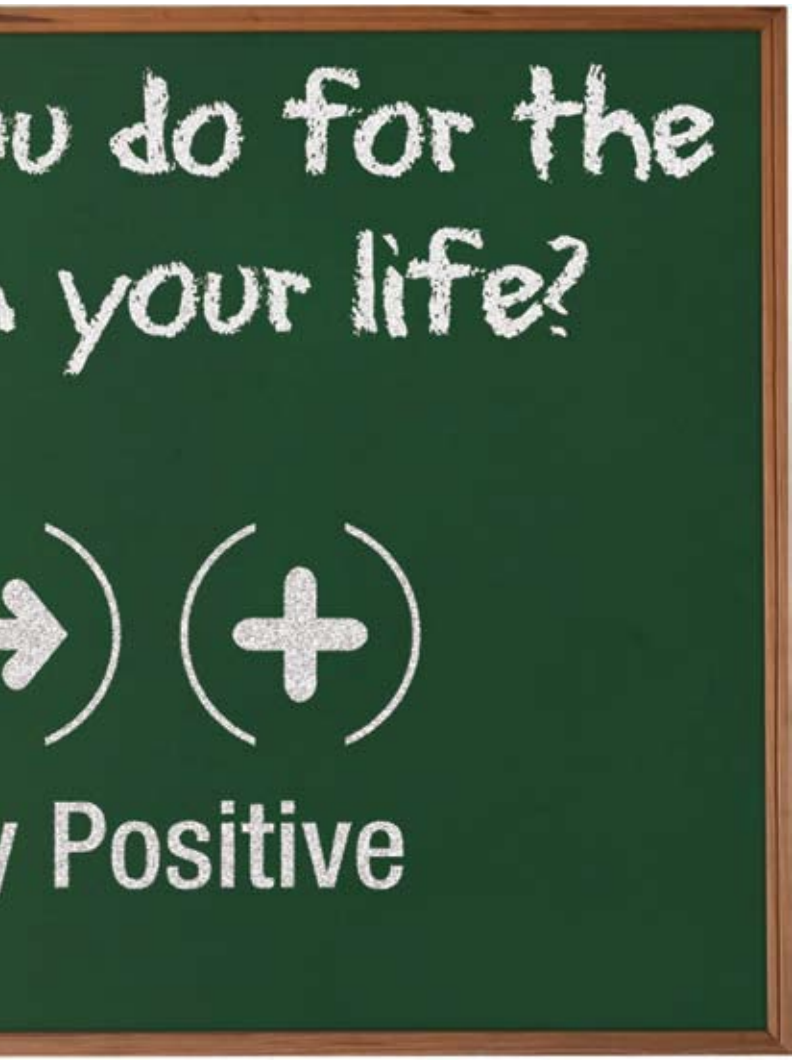
- Children need adults to create safe environments that are free from weight-related bullying and teasing, that educate about body size as a diversity issue, and that honor and support the physical changes that occur in developing bodies. Programs such as The Body Positive and Kathy Kater's *Healthy Body Image: Teaching Kids to Eat and Love Their Bodies Too!* need to be implemented in every elementary, middle and high school in the country. Dialogue about body image, beauty ideals, Health At Every Size and size discrimination must exist at every educational level. Every person, and especially young people, needs a place to go that is free from judgment, comparison and criticism!

- Self-love and respect must be the guiding principles for any lifestyle changes suggested for a child who is out of balance with her eating and physical activity. All nutritional teaching must be done from a positive place instead of instilling fear in children for desiring foods that taste good. "It's important to eat green vegetables because they give your body what it needs to be strong, so you can climb a tree, play kickball, play soccer," is a wonderful way to teach a young child to eat broccoli rather than, "It's good for you, just eat it, and no dessert unless you do!"

- Children need to be taught to self-regulate in regards to eating and movement before they leave home. It is actually possible to teach a child to make good decisions about food and movement without being a dictator! Using the principles of nutritionist Ellyn Satter ***(www.ellynsatter.com)*** when teaching young children about food is a great place to start. Helping a child listen carefully to her body's needs and desires and to make her own decisions (even if they are "mistakes" in our eyes) helps her achieve mastery in becoming an intuitive eater. **Young adults just entering the world would not binge on formerly forbidden foods if they were intuitive eaters when they left home.**
- Media literacy must begin as soon as a child watches television and tunes into the messages of media. Cultural images of beauty for both girls and boys can be analyzed, even with young children. It doesn't mean that the child can't play with her Barbie or watch *The Little Mermaid*, but she must understand the impact of the image and know that it is only one person's idea of beauty. It is important to help children and teens understand who is making money off the messages they are given, especially messages that promote body dissatisfaction with the goal of selling products.
- Children need adults to **listen** to their concerns without being brushed off as silly or ridiculous, and to be their **allies** by creating safer and more positive environments. The boy who comes home sad because he was teased for being fat needs to be given space to voice his pain. **The parent must go to the school and talk to the administration about implementing programs and policies to address size discrimination, as opposed to putting her child on a diet in hopes of stopping the teasing by trying to change his body size.**
- Children need FUN physical education programs in their schools on a daily basis. The goal should be to encourage a lifetime of movement rather than focusing on fat testing and running the mile at a certain speed.
- Young people need tools to turn life's negatives into positives. The Body Positive logo is three brackets in a row with a negative sign in the first, an arrow in the second and a plus sign in the third. The symbols indicate that it is always possible to take a negative situation, add the power of a change agent, and turn it into a positive. Losing six years of my young life to bulimia and my obsession with weight, along with the death of my sister due to complications from breast implants and a lifetime of eating disorders,

could have left me numb and resigned to the belief that it is impossible to prevent eating and body image problems. What were the change agents in my life that allowed the development of an organization focused on positive action? My own recovery in my early twenties with an emphasis on LIVING life, and my desire to change the world for my daughter and the two children my sister left behind when she died. It was, and still is (even after 10 years of struggle to keep a non-profit organization alive), my belief that we can create a world that supports the development of healthy, whole and happy children who grow up into healthy and positive adults with the power to make this world a better place for all human beings.

The number of young people who are learning that it is possible to love and nurture their natural bodies is growing. They are opting to reject information and imagery that have only led to self-destructive and unhealthy behaviors, and are making the choice to live by trusting their bodies' innate wisdom to know when, what and how much to feed themselves, and to find physical activities easily maintained over a lifetime that nourish both their bodies and their souls. They have the ability to critically examine the messages they receive from their world. They understand the difference between image and real health. They know that real health is not solely achieved in a thin body. They have had a change of focus. ☆



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ABOUT: Connie Sobczak, BA

Connie Sobczak, BA, is the Co-Founder and Executive Director of The Body Positive. She is a writer, poet, filmmaker and mother. She uses these skills and her former struggles with eating and body image issues to shape The Body Positive's vision and creative projects. She created the BodyTalk video series and co-wrote the BodyAloud! guidebook based on her desire to create a world where children can grow up feeling beautiful, confident and healthy in their unique bodies. Connie is a body image coach, and is writing a book of essays and poetry to inspire people to move beyond body dissatisfaction into vibrant and creative lives!

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PROMOTING HEALTHY BODY IMAGE

A Holistic Approach To Eating, Nutrition, Fitness And Weight In Children In Schools And At Home

Kathy J. Kater, LICSW

At a time when they should feel secure about their body's growth, too many children today learn to feel anxious about size and to make choices that cause the very problems they hope to avoid. By the time they are in sixth grade, over half of America's girls personally relate to the words of this older teen:

> *Actually, I felt pretty good about my body until about 6th grade.*
>
> *But then everyone else hated theirs so I thought I should too.*

Roughly 75% of today's adolescent girls of every size say they are unhappy with their weight. "Feeling fat" is by far the most common reason for this dissatisfaction. In turn, the vast majority of girls today—from 60 to 70%—learn from the media, their peers, their families, and their communities that they should engage in "dieting" (restrictive eating for the purpose of weight loss) to try to achieve the slender figure that will be deemed acceptable. Once prevalent only among college age females, "feeling fat" (always with a negative connotation) and the belief that they should restrict eating to lose weight now affects a significant number of grade school children. Surveys report that up to 81% of girls ages 8 to 10 feel "very afraid of gaining weight" and 35% (still in their prime growth years) had already tried dieting to shrink their size. Boys are not immune from body image concerns, longing for the lean but "ripped" look. While in 1972, only 18% of males said they "disliked their upper torso" the percentage has risen to nearly 50% today.[1]

The compelling wish to be thin or lean at all costs provides the seeds for a host of body esteem, eating, nutrition, fitness, and weight problems that are extremely difficult to reverse once established. Children who worry about being (or becoming) fat are self-conscious, anxious, distracted, preoccupied by the food they feel they shouldn't eat, and sometimes depressed. Precisely at a time when their primary developmental task is to discover *who they are*, they feel they should worry more about *how they look*. In response, unhealthy eating is virtually guaranteed as eating with the goal of forcing their bodies to conform to a prescribed size takes precedence. Dieting for weight loss requires that the dieter disconnect from internal hunger cues to eat according to a prescribed plan. In response, children who are put on diets learn not only to feel that their innate appetites are bad (too big), but that in order to be acceptable, they must hide what they want—adequate food of course, but other expressions of who they are as well. This disconnect has long ranging and destructive repercussions for both physical health and emotional well being.

The negative effects of anxiety about weight are easily seen when we step back from mainstream pressures that urge this worry. Even parents who themselves are still hooked by the thin ideal and diet mentality do not want their children to suffer the consequences of body dissatisfaction and poorly balanced or inadequate nutrition. Yet—especially under the influence of headlines announcing a "war on obesity"—parents worry, "Doesn't my child *need* to worry about fatness to avoid becoming unhealthily fat?" This question is best answered by asking another: since weight loss has become a normative quest in the past forty years, have people succeeded in reaching their goal? Given the number of participants and America's "can do" spirit, one could surely expect a slim and trim population by now. The fact is, as the drive to be thin and the diet mentality have spread across the land and around the world, so has a coinciding increase in fatness. Yet directives continue for "solutions" that ignore the big picture: the thinner we have tried to be, the fatter we have become.

Fortunately, enough is now understood about the causes of body image, eating, nutrition, fitness, and weight concerns to turn this around. The Model for Healthy Body Image (MHBI) provides a new, holistic approach to help individuals, families and school communities to value health and resist pressures that promote negative body images and counterproductive lifestyle habits. The concepts in this model have been tested clinically in a popular and successful curriculum called *Healthy Body Image: Teaching Kids to Eat and Love Their Bodies Too!*[2] This curriculum demonstrated very positive results in outcome studies with students in grades four through six,[3,4] and it is endorsed by the U.S. Department of Health Office of Women's Health in their Bodywise information packet for educators. A companion book for parents, entitled *Real Kids Come in All Sizes: Ten Essential Lessons to Build Your Child's Body Esteem*[5] is now available to help parents to reinforce the same health principles at home. With this holistic model, children—as well as their parents and teachers—can avoid problems of prior approaches and embrace a more successful way.

Problems with Non-Holistic Body Image, Eating, Fitness and Weight Models

Various perspectives and prevention initiatives targeting one or another type of body image, eating, fitness or weight problem are currently promoted to lay and professional audiences. For the most part these approaches are driven by valid concerns. However problems occur with any perspective that does not consider the *whole big picture*. A viewpoint that is too narrowly focused means that critical phenomena are likely to be neglected, resulting in recommendations, however well intentioned, that are either fundamentally flawed or insufficient to address the big picture.

For example, programs concerned about the development of negative body images often target the unrealistic "thin ideal" and the all-pervasive diet mentality it has spawned—two well documented contributing factors to body dissatisfaction and disordered eating. However warning students about *what to avoid* does not provide the guidance they need about *what to do instead* (in their diverse sizes and shapes) to maintain healthy body image, eat well, and be fit in a social and cultural context that does not particularly support these. Students need a more comprehensive approach.

Other "camps" have declared a "war on fatness, and urge weight loss as essential to the health of the American public. Health is a universal concern. But denial of the vast body of research regarding size diversity means that prescriptions for weight loss are prescriptions for failure for a significant segment of the population whose genetic predisposition naturally defends a higher weight. Likewise, rejection of evidence demonstrating that health is influenced (to the degree that it is within our power to influence) primarily by *lifestyle choices* (rather than size) results in recommendations for weight loss that actually contribute to problems that deserve effective solutions.

Others advocate a return to intuitive eating and/or size acceptance. These advocates are fully justified in their anger about the oppressive and pervasive power of weightism and the shame about hunger this encourages.

However, in their zeal to advance what is probably the only method to truly eradicate "food issues," some of these proponents may resist addressing the broader cultural arena that can make it difficult for many children today to retain the ability to eat intuitively. In light of current normative and widely promoted eating styles—dieting (on the one hand) and eating "whatever/whenever" (on the other)— few parents feel truly competent about how to eat well and effectively themselves, let alone how to guide their children in doing the same.

Figure 1

THE MODEL FOR HEALTHY BODY IMAGE

Conceptual Building Blocks	Foundation	Desired Outcome	Goal
Developmental change is inevitable. Normal changes may include weight gain and temporary out-of-proportion growth. Fat does not, by itself, define "overweight." Genetics and other internal weight regulators strictly limit the degree to which shape, weight & Body Mass Index can be manipulated through healthy means. Restricted or restrained hunger (dieting) results in predictable consequences that are counterproductive to sustained weight loss and interfere with normal hunger regulation.	Recognize and respect basic biology; understand what cannot be controlled about size, shape and hunger.	Accept the innate body: "This is the body I was born to have."	Healthy Body Image Prevention of Unhealthy and Disordered Eating
Balance attention to many aspects of identity. Looks are only one part. Satisfy hunger completely with enough varied, wholesome food in a stable, predictable manner on a regular basis. Limit sedentary choices to promote a physically active lifestyle through all stages of life. Choose role models that reflect a realistic standard and enhance self esteem.	Emphasize what can be influenced or chosen.	Enjoy eating well for health, energy, enjoyment, and hunger satisfaction. Create a physically active lifestyle for fitness, endurance, fun, relaxation and stress relief.	
Promote historical perspective on today's cultural attitudes related to body image. Develop media literacy. Learn to think critically about media messages that influence body image. Support others in resisting unhealthy norms about weight, dieting, low nutrient food choices, excessive eating for entertainment, and sedentary entertainment.	Develop social and cultural resiliency.	Develop autonomy, self esteem, confidence, and the ability for critical thinking.	

Approaches that neglect or discount the legitimate concerns of alternative perspective are destined to fail. With blinders, solutions are proposed that gloss over important contributors to the problem, are short-sited, or that are blatantly flawed. In this light, how can we be surprised when the public is confused, frustrated, and in many cases, complacent about healthy lifestyle choices?

It is clear that a broader, more holistic perspective is needed that simultaneously targets the seedbed for the unrealistic drive to be thin and counterproductive dieting behaviors, the rising rate of fatness, and weightist attitudes that deny the integrity of size diversity *without contradiction*. The MHBI was designed for this purpose. The model is based on the supposition that any viable solution must recognize that unhealthy weight (over- or underweight), values and choices about eating and physical activity, the pervasive thin "ideal," negative body image, the diet mentality, and weightism are not separate concerns, but are all part of one dynamic, interrelated problem.

Development of a Comprehensive Model: The MHBI is a pro-active, comprehensive health promotion model, built on the principle that positive body esteem and internal hunger and weight regulation are fully functional in healthy infants at birth. In an ideal world, all that is needed is a supportive environment to maintain what is there from the start. In this light, if problems occur among large numbers of people in a population, it is assumed that these are culturally mediated—spawned by a cultural context in which body image, eating, nutrition, fitness and weight problems and are promoted—not due to individual weakness or circumstance.

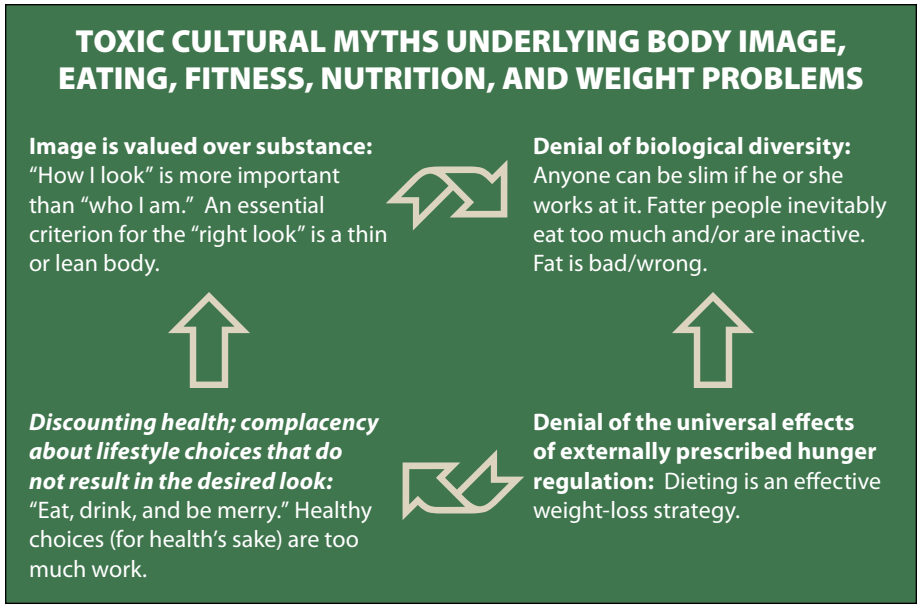
Concepts contained in the MHBI are a response to a set of pervasive, distorted, culturally transmitted beliefs that together have proven to promote body image, eating, fitness, and weight problems in modern Western environments. This set of *toxic myths* serves as the seed-bed out of which problems take root and grow. The model provides ten prevention principles or *antidotes* that directly challenge the premises of these myths, and empower resistance to their negative influence. In turn, healthier attitudes and behaviors are maintained or reinstated. The antidotes teach **a) the biological limits to manipulation of body size and shape through healthy means, b) choices that enhance healthy weight, body image, and self esteem,** and c) **actions for resiliency in the face of conflicting messages.** Figure 1 illustrates this organization.

The MHBI vigorously avoids short-term-only solutions. It rejects methods that appear to solve one problem, but at the expense of another. The goals and the means to reach them—healthy body image attitudes, healthy lifestyle choices, and healthy weights—are equally attainable for all, regardless of size, shape, weight, age, gender, socio-economic status or cultural milieu. As such, the model is non-discriminatory, simple enough to be taught to children as well as adults, and equally useful for prevention or reversal of problems.

Interdependent Toxic Myths are Challenged by the MHBI Antidotes: As with any holistic model, it is essential to keep all four toxic myths or contributors to body image, eating and weight problems in mind in order to avoid solutions that neglect part of the problem or conflict (see Figure 2). The myths are summarized here, followed by the prevention principles or antidotes that challenge their unreliability.

Myth 1: Image is valued over substance: "How I look" is more important than "who I am." An essential criterion for the "right look" is a thin or lean body: Given the human need for inclusion, that which is perceived as normal carries tremendous value. Insecurity

Figure 2



about meeting the current accepted standard is a desired outcome for advertisers who can then offer products that promise to correct the perceived deficiency. In this way, intensive, systematic marketing that presents ultra thin females and highly sculpted males as if they were normal has been very effective in creating tremendous appearance anxiety in general and fear of fatness in particular in individuals who naturally want to be normal and fit in.

The MHBI antidotes teach children to resist to objectification:

- Acquire historical perspective on today's body image attitudes. Understand that an emphasis on an "ideal look" is a set-up for unhappiness.
- Develop a strong sense of identity based on a balance of inner qualities rather than on appearance.
- Become media literate and recognize advertising strategies. Think critically about media messages that encourage unrealistic, unhealthy body image attitudes and low nutrient, sedentary lifestyle choices.

Myth 2: Denial of biological diversity: Anyone can be slim if he or she works at it. Fatter people inevitably eat too much and/or are inactive. Fat is bad/wrong. For the drive to be thin to be widely embraced, biological diversity of size and shape must be generally denied. The current norm is to mistrust the body's ability to regulate weight if/when the end result is or might be visible fat. Instead of accepting that wholesome eating and fitness result in diverse but healthy fat to lean body compositions for each individual, external standards are trusted to determine the "right" weight. Since any degree of fatness is assumed to be bad, prejudicial attitudes regarding it have become rampant.

The MHBI antidotes teach children the biological principals of size diversity:

- Understand the normal, expected addition of body fat that is common during puberty and other developmental stages of life.
- Respect and appreciate the genetic diversity of body shapes and sizes.
- Understand how the internal weight regulatory system limits the extent of long-term control that is possible over weight.

Myth 3: Denial of the universal effects of externally prescribed hunger regulation: Dieting is an effective weight-loss strategy: Given the drive to be thin and denial of size diversity, a means of achieving weight loss is needed. Since restrictive eating results in short term weight loss for most people, this is routinely presented as evidence that anyone can be slim(mer) if they work at it. Denial of the long term, counterproductive effects of dieting for weight loss is essential to support the drive to be thin. Most people (including many medical providers) continue to blame a dieter's lack of willpower, rather than accept that the method is intrinsically flawed. Beliefs about the efficacy of dieting are boldly transmitted without qualifiers side by side with the thinness schema, creating dual pressures for an unsuspecting public who are not well educated about the expected and predictable outcomes: Preoccupation with food, ravenous hunger, disconnection from internal hunger cues, moodiness, compulsive rebound eating, and regained weight (often with added pounds.)

The MHBI antidote teaches children the facts about dieting for weight loss:

- Recognize that there are predictable, counterproductive results when hunger is restricted according to an external plan. At least 90% percent of weight lost through dieting is predictably regained, usually with added pounds.

Myth 4: Discounting health; complacency about lifestyle choices that do not result in the desired look: "Eat, drink, and be merry." Healthy choices (for health's sake) are too much work. In a context in which appearance, the drive to be thin, denial of biological size diversity, and the diet mentality dominate, the primary purpose of eating and fitness as a valued part of life are lost. Frustrated that dieting and exercise do not provide them with the promised lean look, many become complacent or defiant about choices for the sake of health: "Why should I eat healthy (or be active) if it won't make me thin?" Marketers capitalize upon this, promoting an expanding array of cheap, readily available, highly flavored, seductively packaged, high energy/low nutrient treats as if these were the basis for a healthy diet, along with an ever growing selection of sedentary entertainment options. Awash in this environment, the number of people who routinely override their internal hunger and weight regulatory system, are poorly nourished, and lack basic fitness has increased exponentially. Since the ensuing recommendations

generally urge restrictive eating for weight loss as the solution, problems are thus perpetuated.

The MHBI antidotes teach children to value health, not size:

- Value balanced nutrition in its own right. Satisfy internal hunger cues with enough wholesome foods to provide the nutrients and energy needed. Enjoy entertainment eating that does not crowd out hunger needed for balanced nutrition or ignore hunger satiation.
- Value movement in its own right. Spend enough time and energy in physical activity to maintain fitness level throughout the life cycle. Enjoy sedentary entertainment that does not get in the way of more active choices that maintain physical strength, agility, and endurance.
- Accept that diverse sizes result from healthy choices. Seek realistic role models that enhance self esteem. Resist pressures about prescribed weight standards, dieting, and an imbalance of sedentary entertainment.

In practice, the MHBI concepts are best conveyed through simple language using examples, stories, and experiential activities. Interested readers may find it helpful to obtain the *Healthy Body Image* curriculum or *Real Kids Come in All Sizes* for engaging methods of effectively teaching these concepts. These publications may be ordered from ***www.nationaleatingdisorders.org*** (click on NEDA Store). The Body Image Building Blocks (Figure 3) and Ten Essential Lessons to Build Body Esteem in Children and Adults (Figure 4) demonstrate how the same MHBI messages may be presented in diverse written formats. These and other educational handouts may be downloaded from ***www.bodyimagehealth.org*** and copied for educational purposes or home use.

Figure 3

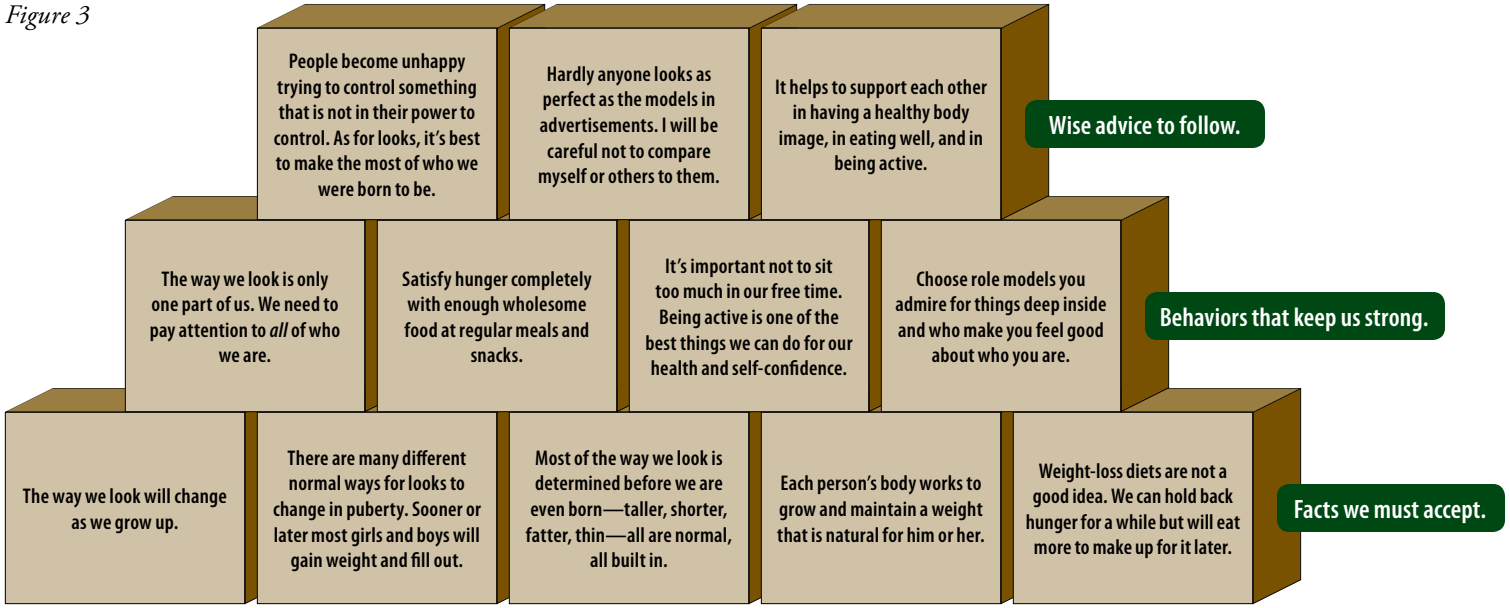


Figure 4

TEN ESSENTIAL LESSONS TO BUILD BODY ESTEEM IN CHILDREN AND ADULTS

To begin, accept what is *not in your control:*

1) Accept your body's genetic predisposition. All bodies are wired to be fatter, thinner, or in between. This includes fatter in some places and thinner in others. Regardless of efforts to change it, over time your body will fight to maintain or resume the shape it was born to be. You may force your body into sizes and shapes that you prefer, but you can't beat Mother Nature without a tremendous cost.

2) Understand that all bodies change developmentally in ways that are simply not in your control through healthy means. You may positively influence changes of puberty, pregnancy and lactation, menopause, and aging by making healthy lifestyle choices, but you will not "control" these changes, no matter how much you try.

3) Never "diet." Hunger is an internally regulated drive and demands to be satisfied. If you limit the food needed to satiate hunger completely, it will backfire, triggering preoccupation with food and ultimately an overeating or compulsive eating response. You may lose weight in the short run, but 95% of weight that is lost through dieting is regained, plus added pounds. Dieters who go off their diets only to binge are not "weak willed." They are mammals whose built-in starvation response has kicked in - both physically and psychologically, going after what has been restricted. Scientific evidence has been available on this since the early 1950's, but most people are not aware of the biologically predictable, counterproductive results of "dieting."

Then focus your attention and energy on what is *within your power* to achieve:

4) Satisfy hunger completely with plenty of wholesome, nutrient rich foods chosen from the core of the food pyramid - eat well! In today's world, surrounded by taste stimulating, cheap, cleverly advertised, readily available, low-nutrient entertainment foods, learning to feed your body versus merely "eat" is an essential difference.

5) Limit sedentary entertainment. Move aerobically, if possible, on a regular basis. Everyone who is not medically inhibited, regardless of size, can and should develop a reasonable level of fitness and maintain it throughout the life cycle.

6) Understand that if you eat well and maintain an active lifestyle over time, your best, natural weight will be revealed. Set a goal to eat well and be active. Don't be swayed by whether or not this makes you thin. Healthy, well fed, active bodies are diverse in size and shape, from fat to thin and everything in between. Don't let anyone tell you otherwise, not even your doctor, who may be caught in unhealthy cultural myths about weight.

7) Choose role models that reflect a realistic standard against which you can feel good about yourself. If the "Ugly Duckling" had continued to compare herself to the ducks she'd still be miserable, no matter how beautifully she developed.

8) Maintain your integrity as a human being. In spite of advertisements seducing you to believe that "image is everything," Never forget that how you look is only one part of who you are. Develop a sense of identity based on all the many things you can do, the values you believe in, and the person that you are deep inside.

9) Become media savvy. Educate yourself about the hidden power of advertisements. Advertisers spend tons of money on strategies specifically designed to make you feel there is something wrong with you. Why? If they first advertise an unrealistic standard of beauty that leaves you feeling deficient by comparison, a product that promises to improve your condition is an easy sale. Don't be "sold" this bill of goods.

10) Encourage your friends and co-workers to join you in developing a healthy, realistic body image. Use the collective energy your group would have spent on hating your bodies to make the world a better place. Help the next generation to develop healthy body image attitudes and learn positive lifestyle habits too.

Conclusion: More remains to be learned about challenging the destructive messages that erode body esteem and cause eating and fitness habits to be devalued. However, in today's milieu of conflicting, counterproductive and dangerous "solutions," the maxim, "first, do no harm," was never more relevant. A holistic, comprehensive, fundamentally sound, non-contradictory, non-discriminatory approach is essential to reverse the current trend. The MHBI is a proven, common sense, health promotion alternative that satisfies these criteria. ☆

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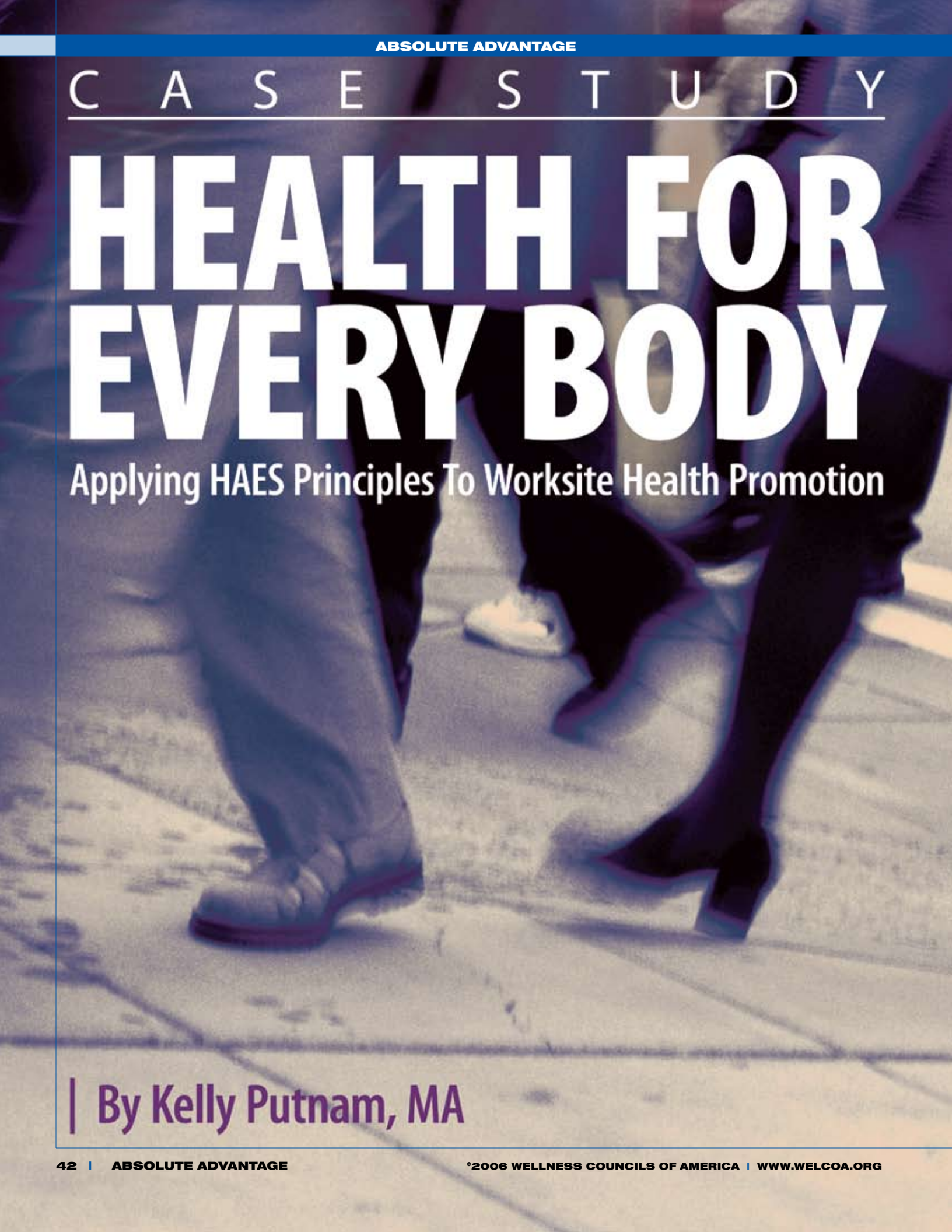
CASE STUDY

HEALTH FOR EVERY BODY

Applying HAES Principles To Worksite Health Promotion



By Kelly Putnam, MA

When I was hired at Mercy Medical Center-North Iowa in 1997 as the employee wellness coordinator I was absolutely convinced that I was going to be the one who finally got Mercy's 2800 employees, 44% of whom were classified as overweight or obese, IN SHAPE. Never mind that no one in the history of health promotion has been able to demonstrate long-term successful weight loss and fitness outcomes for the masses, I was determined to be the first.

My game plan included a failsafe line-up of health promotion strategies designed to educate and motivate even the most reluctant of my participants to take control of their eating and exercise habits once and for all. There would be aerobic classes, walking clubs, and weight loss programs all operating at full capacity. There would be no junk food on campus – only healthy options available in the vending machines and cafeteria. The staff would get thinner and more fit with each passing month under my gifted leadership.

And when the production assistant from *60 Minutes* called to schedule an interview with the genius wellness programmer who had managed to take an entire hospital staff from fat to fit, I would be ready for my close-up.

Well as they say: That was then, this is now.

Luckily, somebody stopped me before I could do any real damage. It was actually two somebodies – Karen Carrier and Jon Robison. I heard them lecture on the non-diet, size acceptance approach to weight issues in 1997 just weeks before taking the job at Mercy and from that moment on, my views on weight and health were forever changed.

Today, some 8 years later, I can proudly say, strange as it may sound at first, that Mercy's Kailo (pronounced Ky-lo) employee wellness program has never offered weight management programs, weight loss contests, or weight-based incentives of any kind as part of our efforts to improve the health and wellness of our employees.

What do you mean you don't offer weight management programs to employees?

Having subscribed to a non-diet, size acceptance philosophy since Kailo's inception in 1998, we've been asked this question countless times by our participants, our organizational leaders, and our peers in the field of health promotion. It's a fair question, but a difficult one to answer succinctly. Over the years, we've had lots of practice in articulating our response. Although we believe Dr.Glenn Gaesser's presentation of the data in his book "Big Fat Lies: The Truth About Your Weight and Health" to be sound, we learned early on in a healthcare environment that the "weight and health are not as closely related as we've been led to believe" argument is a very tough sell. (That's putting it mildly). So we built our case around the other compelling reasons for not promoting weight loss in the workplace:

1. **Lack of efficacy.** The failure rate associated with trying to lose weight through food restriction of any kind is estimated at 90 to 95%. Despite these near impossible odds, more people are dieting than ever before. This begs the question: *In what world outside of the weight loss industry is a five percent success rate considered a good outcome?* Would we prescribe a drug with such a high failure rate? Would we drive a car that only started five to ten percent of the time?

2. **Poor investment.** Let's face it, as worksite health promotion practitioners over-funding is not one of our challenges. Given that so many of us are working with so little, wouldn't it make sense to put our limited resources where we think we can get the most bang for our buck? Put aside for a moment how you feel about the weight issue and just ask yourself from a business perspective: Does funding any type of program in which half the participants drop out and 95% of them do not succeed sound like a good investment to you?

3. **Iatrogenic effects.** Because we pride ourselves on being highly customer-focused, one of the most difficult aspects of adopting a non-diet, size acceptance approach is the feeling that we are not providing something our customers so desperately desire. And to tell you the truth, if we thought the worst that would happen is that most people would not succeed, we might offer weight loss programs anyway

just to satisfy our customers. But Francis Berg's work in "Women Afraid to Eat" convinced us that promoting weight loss is not just ineffective, it can be unintentionally, yet seriously harmful.[1] Berg links our culture's obsession with weight and thinness to (1) a dramatic two-fold increase in eating disorders in the past decade; (2) a 55% prevalence of overweight adults (up from just 25% in 1970); (3) an estimated 80% prevalence in women of dysfunctional eating behaviors such as chronic dieting, undereating, overeating, good food/bad food thinking, and fear of food; and (4) size prejudice and discrimination. To Berg's list, we would add increased body hatred and decreased mental health and well-being. In other words, if we want our employees to weigh more and feel worse, offering weight management programs is the way to go.

What We Offer Instead…

Although the Kailo staff has always practiced a non-diet, size acceptance approach, it was not something we had ever promoted in a big way. We knew it would be controversial – not exactly Year One or Year Two material. Maybe not even Year Three or Four. But by Year Seven of our program, we finally felt strong enough in our convictions and ready to take on the challenge.

Using Health At Every Size (HAES) principles, we developed a program called "Health for Every Body" (HFEB) (see Inset A). And in 2004, we took a deep breath and a huge leap of faith and devoted an entire year's worth of marketing and programming efforts to its implementation (see Inset B).

As you might expect, there was some strong resistance to the HFEB message. It's interesting to note that of all the controversial subjects we've covered over the years – including domestic violence, depression, and religious beliefs – the weight issue has been by far the most emotionally-charged health topic we've ever addressed. We were nervous but determined. Our leaders were nervous, but trusted we knew what we were doing. Our physicians were divided – some outraged, some intrigued. Our dietitians seemed pleased that someone else was out there saying "diets don't work." And overall, our employees were surprisingly open to hearing a new perspective on issues of food, exercise, weight, and health.

What We've Learned

The year 2004 taught us many things. We learned more about who we are as health promotion practitioners and who we are as people. We made some enemies, but we also gained some allies. Resistance came from all directions, sometimes swift and furious and sometimes from the most unlikely places, but the positive support and affirmation of the people, many of whom for the first times in their lives felt a little less desperate and a little more hopeful about their health and well-being made it all worth it.

I wish I could report that our year-long HFEB focus resulted in Mercy becoming a non-diet, size acceptance hospital – but that would be overstating it quite a bit. We still have weekly requests from our participants to offer weight management programs. We still have some nursing units organizing their own weight loss competitions. We

Inset A

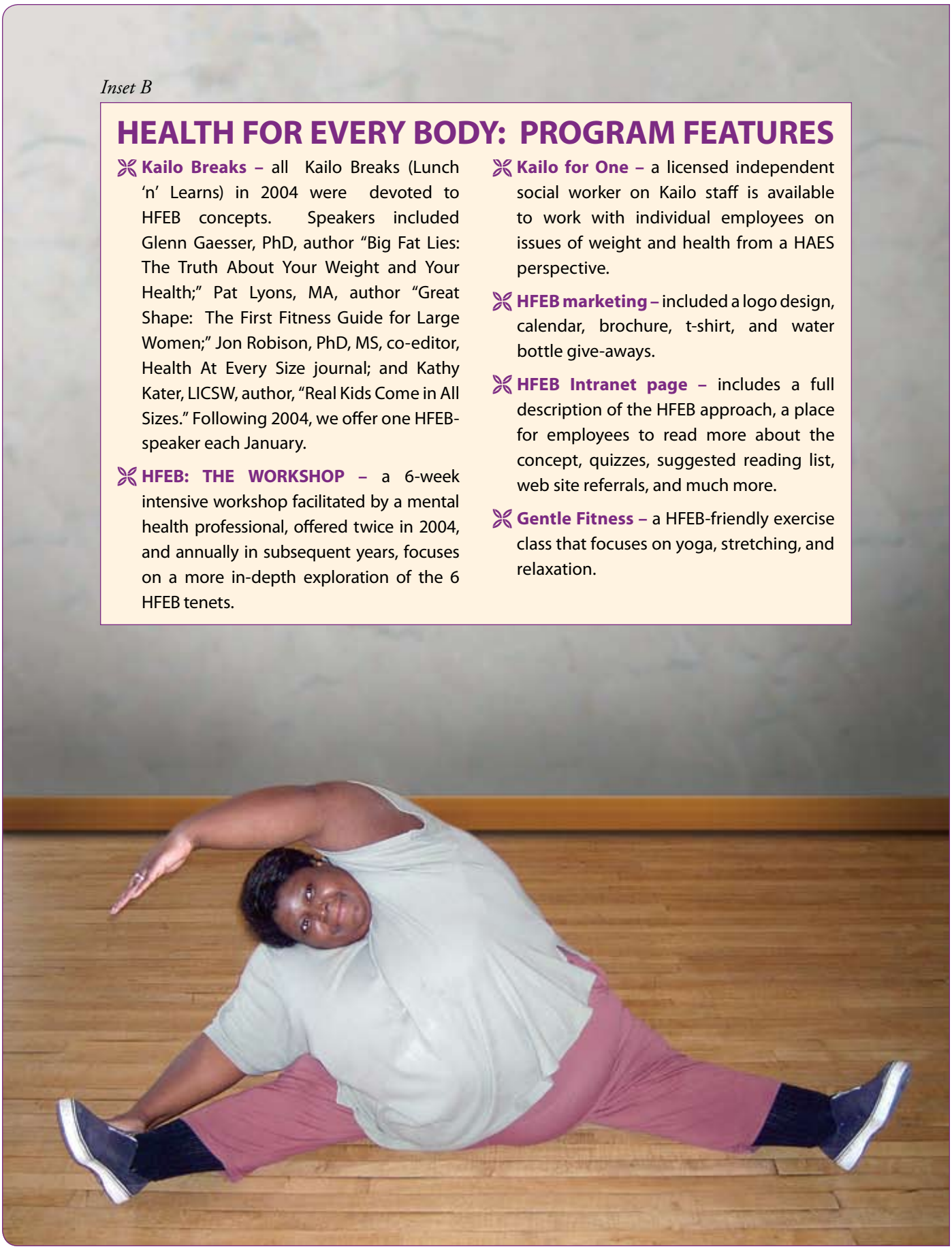
HEALTH FOR EVERY BODY: SIX TENETS

- **Education –** to provide the latest scientific research on weight and health that is not typically covered in the mainstream media.
- **Normal eating –** to teach participants how (1) to eat in response to internal, rather than external cues; (2) to refrain from dieting (restricting foods); and (3) to avoid "dieter's mentality," which includes good food/bad food thinking, fear of food, chronic dieting, and starving/bingeing cycles.
- **Movement for pleasure –** to de-emphasize weight loss and body sculpting as the primary goals of physical activity and emphasize pleasure, feeling good, and increased energy.
- **Self-acceptance –** to encourage participants to work on issues of body hatred from the "inside-out."
- **Social support –** to recognize the role of relationships in addressing issues of weight and health and to build a supportive network of HFEB-friendly health professionals in our community.
- **Size tolerance –** to advocate for the fair and equal treatment of people of all shapes and sizes.

Inset B

HEALTH FOR EVERY BODY: PROGRAM FEATURES

- **Kailo Breaks –** all Kailo Breaks (Lunch 'n' Learns) in 2004 were devoted to HFEB concepts. Speakers included Glenn Gaesser, PhD, author "Big Fat Lies: The Truth About Your Weight and Your Health;" Pat Lyons, MA, author "Great Shape: The First Fitness Guide for Large Women;" Jon Robison, PhD, MS, co-editor, Health At Every Size journal; and Kathy Kater, LICSW, author, "Real Kids Come in All Sizes." Following 2004, we offer one HFEB-speaker each January.
- **HFEB: THE WORKSHOP –** a 6-week intensive workshop facilitated by a mental health professional, offered twice in 2004, and annually in subsequent years, focuses on a more in-depth exploration of the 6 HFEB tenets.
- **Kailo for One –** a licensed independent social worker on Kailo staff is available to work with individual employees on issues of weight and health from a HAES perspective.
- **HFEB marketing –** included a logo design, calendar, brochure, t-shirt, and water bottle give-aways.
- **HFEB Intranet page –** includes a full description of the HFEB approach, a place for employees to read more about the concept, quizzes, suggested reading list, web site referrals, and much more.
- **Gentle Fitness –** a HFEB-friendly exercise class that focuses on yoga, stretching, and relaxation.



still have physicians recommending diets to our patients.

You might think this would be disheartening to us after all our hard work but the truth is we never expected to subvert the overwhelming power of the dominant paradigm on a systemic level (although it does make for a delicious fantasy!). Our goal was simply to convince our organization's leaders to let us give voice to an alternative approach. And on that front, we have absolutely been successful. To date, we are one of the only healthcare organizations in the country that is even allowing an HAES viewpoint to be heard. And for that, we are very proud and grateful.

HFEB: The Study

In addition to our year-long focus on HFEB programming for our entire worksite population, we recruited 61 Mercy employees to participate in a 12-month observational study to determine how exposure to the HFEB approach might impact health outcomes. A summary of the study, which was modeled after a similar study conducted by Linda Bacon at the University of California-Davis, is provided below.[2,3]

Recruitment/Selection

Sixty-one (60 female; 1 male) subjects were recruited via e-mail and Kailo Break announcements.

Education

Each participant met with a study leader to review the menu of educational opportunities they could choose to participate in over the course of 2004 (see Inset B). Participants were provided a diary in which to journal their thoughts and track attendance in programs. HFEB study participants were also invited to special sessions with each of the national HAES experts throughout 2004. Study leaders met quarterly with participants as a group to answer questions, address concerns, discuss how participants were thinking and feeling about the HFEB program and foster relationships among group members.

Results

Overall, HFEB participants demonstrated both clinically and statistically significant improvement in body dissatisfaction, depressive symptomology and disordered eating. Participants also appeared to have an increase in physical activity, but results in this category were not statistically significant. Pre and post data were collected from HFEB participants (N = 41) utilizing the following standardized tools:

- ***Beck Depression Inventory II (BDI II)***
  The BDI II measures the presence of depressive symptomology. Scores of 14-19 indicate mild depression, 20-28 indicates moderate depression and 29-63 indicates severe depression. Of all the pre/post measurements collected from HFEB participants, depression scores improved the most. This is not surprising given the link between poor body image, failed dieting, and decreases in emotional well-being. Twenty-seven participants had pre BDI II scores indicating they were not depressed; 14 participants were depressed. None of the non-depressed became depressed and 11 out of the 14 became non-depressed. As a group, HFEB participants indicated a 41% improvement in their BDI II scores, going from a pre-mean of 9.7 to a post-mean of 5.8.

- Reducing depression is no small matter. In fact, its prevalence and high employer-paid health and lost productivity costs, make depression one of the biggest untapped opportunities in worksite health promotion. These results suggest that one of the major benefits of using a HAES approach to weight issues in the workplace may be a reduction in employee depression as opposed to using more traditional weight management approaches that have been associated with a decline in mental well-being.

- ***Body Image Avoidance Questionnaire (BIAQ)***
  The Body Image Avoidance Questionnaire (BIAQ) measures body dissatisfaction by asking

participants to rate the frequency of their avoidance of activities due to body dissatisfaction. Research indicates the average score in samples of patients with eating disorders is a score of 40, and the average woman obtains a score of 30-31.5. As a group, HFEB participant scores improved by 22%, going from a pre-mean score of 30.439 to post-mean score of 23.707.

➤ ***Three Factor Eating Inventory (EI)***

The EI measures disordered eating in three categories; (1) cognitive restraint – the amount of time and energy one spends thinking about food; (2) Disinhibition – one's tendency to overeat in the presence of a disinhibitor such as alcohol, low mood or stress; and (3) Hunger – the participants perception of hunger throughout the day. As a group, HFEB participants indicated a 17% improvement in cognitive restraint scores – meaning they spent less time and energy thinking about food; a 23% improvement in disinhibition – meaning they overate less; and a 37% improvement in hunger scores – meaning they reported feeling hungry less often throughout the day.

➤ ***Stanford Seven Day Physical Activity Recall (PAR)***

The PAR measures a participant's frequency and intensity of physical activity. The participant's post score was compared to his/her pre scores to achieve a percentage improvement. While it's true the HFEB participants' increased PAR scores were not found to be statistically significant overall, as any worksite wellness programmer knows, even small improvements in physical activity can be highly significant to health and well-being on an individual basis.

The Future Of HFEB At Mercy

Now that our year-long focus on HFEB has ended, we remain committed to promoting the HAES principles on a daily basis within the framework of our regular programming. We continue to offer one HFEB-friendly Kailo Break per year, bringing in a national speaker to further educate our participants on the non-diet, size acceptance approach. We continue to offer a 6-week intensive workshop each year for employees who want to explore the HFEB tenets on a more in-depth basis. In addition, we continue to offer one-on-one counseling, Gentle Fitness classes, and a wide-variety of self-study materials on our Intranet site and in our library.

As for the HFEB study group, we offer a monthly support group as well as periodic e-mail postings to stay connected with our participants. Our intent is to collect two-year outcomes in the Spring of 2006. ☆

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ABOUT: Kelly Putnam, MA

Kelly Putnam, MA, is the Health Promotion Coordinator for Mercy Medical Center-North Iowa and the Executive Director and creator of Kailo, a non-traditional approach to worksite wellness. A health educator since 1993, Kelly was the wellness coordinator for North Iowa Area Community College prior to starting at Mercy in 1997. She developed the Kailo concept—one of the first holistic, relationship-oriented wellness programs to be launched in a healthcare setting. The Kailo program has resulted in significant improvement in employees' perception of their health and happiness. Kailo has received a JCAHO "Best Practice" citation, a Platinum Well Workplace designation from the Wellness Councils of America (WELCOA), the Trinity Health Excellence and Innovation Award, and the Iowa Psychological Association's Psychologically Health Workplace Award as well as several national healthcare marketing awards. You can reach Kelly by emailing her at ***PUTNAMK@mercyhealth.com***.

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THE SHAPE OF T

THINGS TO COME

Dr. Jon Robison speaks out on the shortcomings of traditional weight loss approaches and suggests a solution for change.

The failure rate for traditional diet-centered approaches has exceeded 95%. This means that 95 people out of every 100 who try to lose weight fail. For a small but growing group of professionals and advocates, these results are unacceptable. Taking the place of traditional weight-oriented approaches is a new movement… ***Health At Every Size***. To shed light on this new approach, Dr. Jon Robison sat down with WELCOA President, Dr. David Hunnicutt to discuss the nuances.

Explain *Health At Every Size* and how is it different from traditional weight loss approaches in this country.

The major difference on a general level is that typical approaches to issues of weight have been what we refer to as "weight-centered." In other words, the main focus has been on weight. It goes something like this…if you carry too much weight, this will happen to you; if you lose weight, then this will happen to you.

What the *Health At Every Size* philosophy/movement is all about is a "health-centered" rather than "weight-centered" approach—which means that the focus is on the health of the individual **regardless** of the weight.

From our perspective, weight is just not a very good predictor of mortality or morbidity, and we know that most of the health problems that have been attributed to weight are health problems that people of all different weights have if they don't eat well, aren't physically active, or don't take care of themselves.

The bottom line is that we want to take the focus off of weight and put the focus on health. And, of course health in the most holistic sense—mind/body/spirit—not just the physical body but the whole person. That's really the major difference of *Health At Every Size*, health-focused versus weight-focused.

Is the *Health At Every Size* approach gaining popularity?

It is. In fact, it was just mentioned by name in a weight-loss feature story done by *U.S. News and World Report*. Some of the leaders of our movement were quoted in the article and spoke about this different sort of approach and the fact that there really isn't any intervention in the medical field that has the failure rate that dieting does—and yet we keep promoting it.

Now what we're saying is that *Healthy at Every Size* provides an alternative to the standard approach. And, as I go around the country to speak about this, there's resistance just as there is with any new paradigm. But I also see a lot of people lighting up and saying, "Oh my God, I've been trying all these years to get people to lose weight and keep it off. It hasn't been working and here's a potential answer to this; here's a potential way that we can help these people whatever their size is to be healthier."

What would be the major criticism of the *Health At Every Size* message?

Well, the major criticism is "Do you have any proof that your approach works?" That's the one I hear more than any. From where I sit, it's an interesting focus for the critique if you think about it because the evidence is so clear that traditional approaches to weight loss don't work. Even people involved with these approaches often agree. And yet, when you propose a new paradigm, the first question is well we can't do that unless we know that it works, which is really kind of an odd, sort of an ironic critique.

Don't get me wrong. I certainly think it's a valid question to be asked of any intervention. And the interesting thing is that I think the answer to this question is a fairly unqualified yes. Now, if you mean do we have multiple research studies where we pit the best traditional weight loss program against a *Health At Every Size*-type program and we see what happens, the answer is no. However, this is because the approach is so new. But researchers are beginning to study this approach in a clinical setting.

For example, one recent study was published in the *International Journal of Obesity* and then followed up on in the *American Journal of Dietetics Association*. In this study, researchers took a group of obese women and put half of them on one of the most well-known behavioral weight loss interventions. The other half received a *Health At Every Size* approach. Want to guess what they found? Researchers discovered that over the six month period, both groups had similar improvements in a variety of physiological and psychological parameters. In addition, the weight loss group lost weight. The *Health At Every Size* group didn't lose any weight - because it's not part of the intervention. After the study was concluded, researchers followed both groups for a couple of years. Not surprisingly, they found that the people who were on the

weight loss program gained all of their weight back and lost all the benefits that they made by losing weight. The *Health At Every Size* group still maintained their weight —didn't lose or gain any weight—and they kept all of the positive changes that occurred in the first six months of the original study.

If you combine these findings with the numerous studies showing that so-called weight-related variables (blood pressure, cholesterol, blood glucose, etc.) can be positively impacted and often normalized with lifestyle interventions that do not result in significant weight loss and in individuals who remain markedly obese, you have growing evidence that *Health At Every Size* is a viable and effective alternative to current approaches.

Explain the elements of the *Health At Every Size* approach.

There are really three major tenets which include: self-acceptance, pleasurable physical activity, and normal eating. The third tenet, normal eating has also been referred to as mindful eating and intuitive eating. In a nutshell, it goes something like this:

Self-Acceptance. We believe that the most important tenet is self-acceptance/size acceptance, if you will. That is, we believe that people are not likely to do positive things for themselves long-term out of self-loathing. If people are really going to do something good for themselves in terms of whatever you're looking at—nutrition, physical activity, lifestyle—they've got to like themselves first. In fact, I would argue that this would be true of any health promotion/health education intervention. It's got to come out of self-acceptance and self-love, not fear or self-loathing. This is not an easy task given the fact that our culture is so fat-phobic and obsessed with weight.

Pleasurable Physical Activity. The second major tenet of *Health At Every Size* is pleasurable physical activity. In essence, we believe that physical activity is important for human beings—just like the traditional approach does. The major difference is that we separate exercise from weight loss and calorie burning. Actually even, I really believe that, for the most part, people who are not being physically active could really benefit from separating health from physical activity. Because believe it or not, people don't necessarily exercise for health—they exercise and stick to it because they like what they are doing—they find something they love; it's a passion; it brings them pleasure, or it's socially engaging if they're doing it with someone else.

We have to acknowledge that there are a lot of reasons why people stick to physical activity programs aside from just health. So in the *Health At Every Size* approach, we talk about exercise to move the body, not change the body. This is important—and the research backs this up—exercise is really not a very good weight loss intervention. Think about it, you get a 45-year-old woman who hasn't exercised for 20 years and she wants to lose weight, and she joins an aerobic step program for 50 minutes, three times a week. I mean in 8 weeks she can expect to lose a pound or two if you do the math, if nothing else changes. What happens is, of course, after 6 weeks her friend says, "Well, how many pounds have you lost?" She says, "¾ of a pound." Her friend replies, "Oh, that's not very good." She quits and doesn't get all the benefits exercise can provide. This happens all the time.

Normal Eating. The third major tenet of the *Health At Every Size* approach is normal eating. Normal eating is a particular kind of eating coined originally I believe by

Ellyn Satter, but also talked about by many other people using different names like mindful eating, etc. Basically, normal eating is eating from internal cues. In other words, paying attention to things like hunger, appetite, and satiety. I often say that it's different from external eating which is paying attention to external cues like, for instance, Weight Watchers or the Food Pyramid or the Dietary Guidelines. Not that the Food Pyramid and Dietary Guidelines are completely useless, but people could go so much farther in having a healthy relationship with food if they would just pay attention to what they're body is asking them to eat and what the results are when they eat certain foods.

We believe that there are ways to teach people to be normal eaters—to relearn to be normal eaters. In fact, all of us were normal eaters as children. Children eat until they're pushed or restricted by adults. They eat normally according to internal cues; they eat until they're full; they eat when they're hungry, and they stop when they're full.

So in summary, the three major tenets are: Self-Acceptance, Pleasurable Physical Activity, and Normal Eating.

Q Jon, this might sound naïve, but in the *Health At Every Size* approach does an individual accept and acknowledge personal risk factors—things like waist-to-hip ratio, blood pressure, and cholesterol?

I don't think that's a naïve question at all, I think it's right at the heart of the issue.

Risk factors certainly do matter. What is critical to understand, however, is that it is possible for people who have been clinically diagnosed as overweight and obese (using BMI charts) to be perfectly well—that is to have low blood pressure and low cholesterol. In fact, there are many people walking around that are considered by society to be obese who are clearly, very healthy. On the other hand, there are many people who are considered by society to be the epitome of health because they are thin that are very unhealthy.

How will this message be received by those who have "bought into" the traditional weight loss and dieting-centered approaches?

There is no question that some people will have considerable difficulty with this message. One only has to look at the unwillingness of the CDC to correct its epidemiological estimates of overweight people in this country to really answer that question. Indeed, when the new research by the CDC came out, which modified the impact of mortality due to obesity from 400,000+ to roughly 26,000 people, the head of the CDC said that they were not prepared to use the updated numbers. I think this gives you a clear indication of how sensitive this topic and approach is going to be.

Jon, what do you see as the future for *Health At Every Size*?

It is likely to be slow going, but I am optimistic. I am hoping that people will continue to see the reality of the failure of traditional weight loss approaches. I hope they will realize that dieting (self-imposed starvation) and trying to conform to our culture's narrow view of what a healthy person should look like is really futile and potentially harmful.

As more and more people try to lose weight—and fail—I think they will intuitively begin to understand that there has to be a different and better way. I think naturally, they'll turn to the *Health At Every Size* approach where they can better identify with the true quest for improving their health.

I am sure that there will be continued resistance to this new approach. But, with the failure rate of traditional approaches at well over 90%, I believe that *Health at Every Size* has a bright future ahead! ☆

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Health At *Every* Size

A journal for healthcare professionals

EDITORS Jon Robison, PhD, MS
Wayne C. Miller, PhD

This quarterly journal helps professionals understand and practice a compassionate and effective non-dieting approach to resolving weight and eating-related concerns. Weight is an easily exploited health and social concern and the editors are committed to exposing deception, reshaping social attitudes and promoting good health for individuals of every size.

Health At Every Size offers solid research and commentary focusing on each issue's theme, such as fighting fraud and deception in weight loss advertising, protecting our children, and cultural diversity regarding size and weight.

Regular features include:

HAES WATCHDOG

Glenn A Glaesser, Ph.D.
Critique of recently published articles and news stories on obesity, weight loss and health

BODY POSITIVE

Deb Burgard, Ph.D.
Approaching body image as a relationship

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Health At Every Size

In this issue of *Absolute Advantage*, Dr. Jon Robison and colleagues address a very different approach to the complex issues related to weight and health. The movement is called *Health At Every Size* and its rapidly gaining popularity.

By acknowledging three core concepts, self-acceptance, pleasurable physical activity and normal eating, *Health At Every Size* looks to provide a superior alternative for helping people with weight-related concerns.

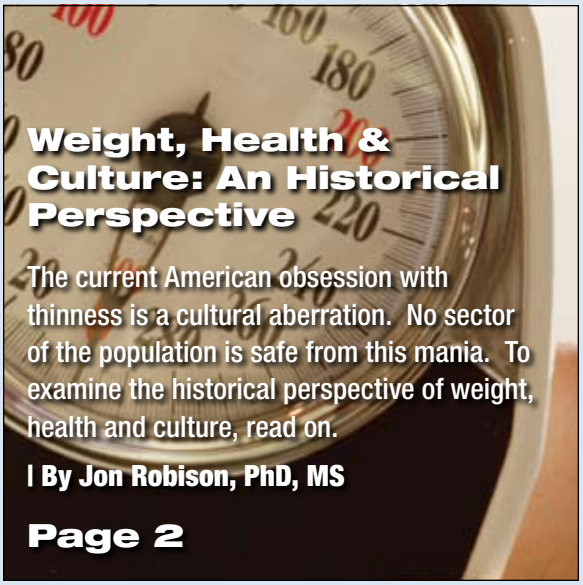
As our invited Executive Editor for this issue, Dr. Robison has called on a number of nationally known and respected leaders. From Ellyn Satter to Glenn Gaesser to Marilyn Wann to Connie Sobczak to Kathy Kater to Kelly Putnam, Dr. Robison has assembled an articulate, qualified and passionate group of authors who share their expertise on promoting *Health At Every Size*.

To be clear up-front, some of the things that you will read in this edition of *Absolute Advantage* will challenge your beliefs and present practices surrounding weight loss and dieting. As with any new approach, thoughtful dialogue and personal examination will be necessary. This issue will challenge you on many fronts.

We are grateful to Dr. Robison for his contributions and we look forward to beginning a new dialogue concerning the idea of keeping people healthy at every size.

Yours in good health,

Dr. David Hunnicutt
President, Wellness Councils of America



Weight, Health & Culture: An Historical Perspective

The current American obsession with thinness is a cultural aberration. No sector of the population is safe from this mania. To examine the historical perspective of weight, health and culture, read on.

| By Jon Robison, PhD, MS

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