

# Compassion for the Larger Bodied Experience

Intentional Weight Loss Data, Treatment Trauma and the Reality of Eating Disorders Recovery

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## A Little Bit About Me

- ❖ Eating disorders & anti-weight stigma activist
- ❖ Experienced behaviors + eating disorders since age 5 (ish)
- ❖ Family hx of eating disorders & chronic dieting
- ❖ Stigmatized & bullied for weight since childhood
- ❖ Substance use and failure to thrive in teen years
- ❖ Began therapy in early 20's - weight management prescribed
- ❖ Finally dx'd with eating disorders in 30's
- ❖ Treatment somewhat effective, but opted for lapband
- ❖ Founded BEDA in 2008
- ❖ Learned about Health at Every Size - treatment greatly enhanced and lapband removed
- ❖ Began "Weight Stigma Awareness Week" in 2011
- ❖ RECOVERY
- ❖ Merged BEDA with another organization in 2018
- ❖ Began Body Equity Alliance in 2022
- ❖ Co-created Altune coaching & groups in 2023
- ❖ Co-founded Mid-Atlantic Collective for Eating Disorders in 2024
- ❖ Helped begin and facilitate larger body and mature individuals group with The Alliance for Eating Disorders




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## Oh, and one more thing...

Language  
The "O" Words  
Person First Language  
(weight loss/pharma industry co-opt)  
Higher Weight  
Larger Bodied

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**Oh, and one more thing...**

Language

**FAT**



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**Agenda**

Topics Covered

- Show Me the Data
- Treatment Trauma & Larger Bodies
- Recovery & Larger Bodies
- How Do We Get There?



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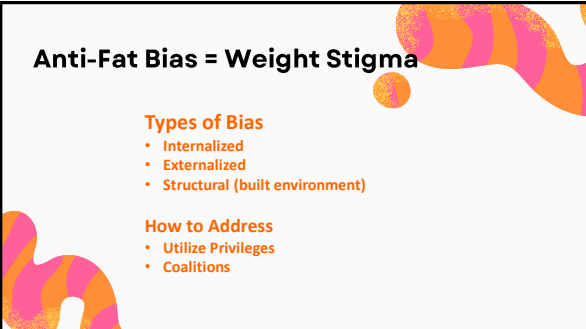
**Anti-Fat Bias = Weight Stigma**

**Types of Bias**

- Internalized
- Externalized
- Structural (built environment)

**How to Address**

- Utilize Privileges
- Coalitions



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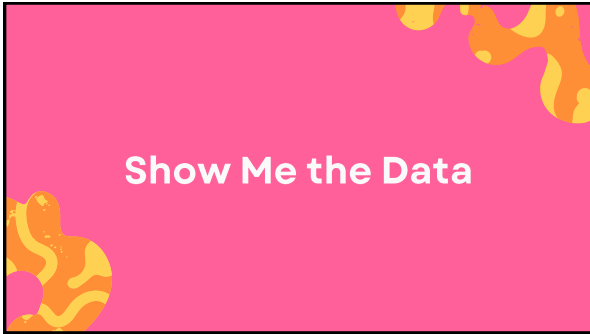
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## Show Me the Data

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## Critical Thinking

*“Researchers have demonstrated ways in which bias and convention interfere with robust scientific reasoning such that obesity research seems to enjoy special immunity from accepted standards in clinical practice and publishing ethics.”*

Mami T, Terajima AI, Whiting E, Lew AM, Samuels S, Chalmers T. Medicine’s Search for Effective Obesity Treatments: Does Any Not Show Another. *Ann Intern Med*. 2007;147:202-210. doi:10.1093/aim.069.A2.3.220.

*“It could be said that weight loss enjoys special immunity from accepted standards in clinical practice and publishing ethics.”*

Aphramor L. Validity of claims made in weight management research: a narrative review of diabetic articles. *Nutr J*. 2010; 9:30. <https://doi.org/10.1186/1475-2875-9-30>

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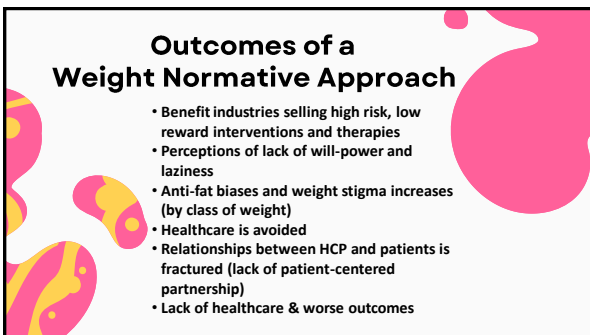
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## Outcomes of a Weight Normative Approach

- Benefit industries selling high risk, low reward interventions and therapies
- Perceptions of lack of will-power and laziness
- Anti-fat biases and weight stigma increases (by class of weight)
- Healthcare is avoided
- Relationships between HCP and patients is fractured (lack of patient-centered partnership)
- Lack of healthcare & worse outcomes

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**The Reality**

- **Most dieters regain weight (80-95%)**
  - Stunkard, et al 1959
  - NIH, 1992
    - WC Miller, 1999
    - Mann, Tomiyama, et al 2007
  - Australian National Medical Health & Research Council, 2013
  - Canadian Expert Panel, 2020
  - Gaesssar & Angoti, 2021

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**The Reality**

- **Most people can lose weight and keep it off for ~ 1 year**
  - Regain 2-5 years
  - 66% regain more than lost
  - “Starvation not sustainable”
    - Ragen Chastain

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### Critiques of the Weight-Centered Health Paradigm Largely Fall Into Three Categories

#### Ideology

- Inconsistent Philosophies
- Ethical Concerns
- Human Rights Denial

#### Technical

- Limited/harmful strategy profiles (e.g. behavior change and social marketing/shaming predominant)
- Health experts as policy and program drivers (absence of lived experience input)
- Singular evaluation of "health outcomes" (only examining weight)

©Hera & Taylor, 2018

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### Critiques of the Weight-Centered Health Paradigm Largely Fall Into Three Categories

#### Empirical

- Inaccurate, insufficient, and oversimplified interpretations of data
- Use of alarmist and dramatized language that does not accurately reflect trends in weight
- Limited focus/scope of information on determinants of body weight
- Inaccurate depictions of the relationship between body weight, morbidity, and mortality
- Weight-loss interventions are consistently ineffective (and often increase weight over time)
- The data consistently support the notion that a "Weight Centered Healthcare Paradigm CAUSES HARM".

©Hera & Taylor, 2018

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### What We Know Actually Works Independent of Weight Loss

- Behavior changes (exercise; relationship with food)
- Healthcare engagement
- Addressing determinants of health (systems)

Tonyama, Allison and Mann, 2013

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## Treatment Trauma & Larger Bodies

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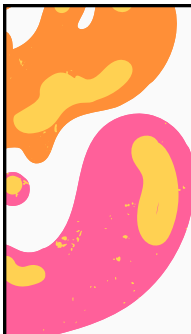
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**“I was diagnosed with AAN last year and at my PCP appointment last week my HCP told me I did not deserve healthcare because of my weight. He told me the only way I can receive healthcare from him is if I go on a weight loss drug and have bariatric surgery.**

**He also told me my eating disorder team is “nuts” to try to convince me I have a restrictive eating disorder.” -MB**

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**“I was terrified to go to a HLOC because I heard the nightmare stories about how I, as a fat person, would be treated by others.**

**My fears came true. Everyone was so scared of the word “fat,” the chairs were too small and I had to sit on the floor in groups, and it was obvious that people did not want to socialize with me. I was on the outside and none of the therapists did anything to make it better for me. -TM**

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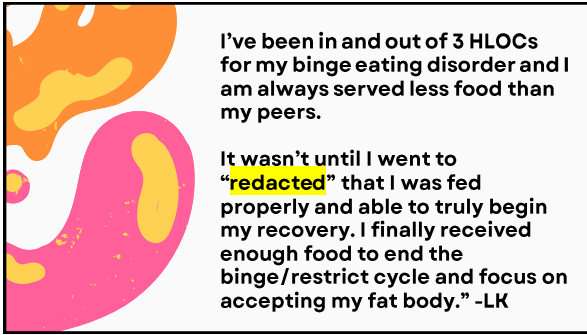
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I've been in and out of 3 HLOCs for my binge eating disorder and I am always served less food than my peers.

It wasn't until I went to "redacted" that I was fed properly and able to truly begin my recovery. I finally received enough food to end the binge/restrict cycle and focus on accepting my fat body." -LK

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### Weight Stigma is a Critical Risk Factor for EDs and Not Addressed in Most Treatment Modalities

**01**

A self-stigmatizing process known as internalized weight stigma

**02**

The experience and internalization of weight stigma are critical risk factors for Eating pathology.

**03**

Anti-fat/pro-thin attitudes are independently predictive of EDs.

**04**

Treatment modalities devote little to no attention to anti-fatness

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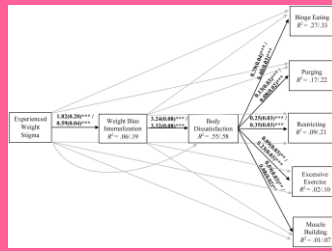
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### Weight Stigma Significantly Increases Transdiagnosis ED Risk & Severity



McEntee et al, 2023

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### Stigma Occurs Through the Convergence of 5 Cognitive/Social Processes

- Labeling of human differences occurs
- Based on these labels, individuals are linked to undesirable characteristics (stereotyped)
- Separation/ostracization occurs (“us” versus “them”)
- Discrimination and loss of status occurs across contexts
- Power differences emerge and are reinforced

(Link & Phelan, 2001)

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### Why is This Happening?



- Unchecked anti-fat biases by treatment providers resulting in stigmatizing experiences.
- Treatment centers not training clinicians.
- Treatment Centers & individual clinicians not doing a weight stigma inventory.
- Lack of larger bodied clinicians to model recovery.
- Continuation of a belief in a failed paradigm amongst some clinicians.

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### Weight Stigma in Treatment for Eating Disorders

Reliance on BMI (and any other measurement) and the weight of individuals engaged in ED treatment  
 Reinforces/further conflates weight with health (for both clients AND providers)

Reassurance vernacular surrounding fear of weight gain

- Reinforces inaccurate beliefs about the possibility and importance of “controlling one’s weight”
- Does not correct the assumptions/negative stereotypes about gaining weight implicit in this fear

Differences in treatment recommendations

- At least 50% of larger-bodied individuals with a history of ED-focused behavioral health treatment report providers recommended dieting and/or encouraged disordered eating behaviors/attitudes in the service of weight loss (Chen et al. 2022)
- Individuals in larger bodies are often praised for weight loss that occurs while in treatment (framed as a “positive outcome” or “successful treatment”)




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### Weight Stigma in Treatment for Eating Disorders

- Missed or minimized diagnoses
  - ED treatment providers minimize or inadequately assess for severe health consequences among individuals in larger bodies.
  - Assumptions that the only eating disorder an individual living in a higher weight body may be experiencing is BED
  - Not challenging insurance companies and diagnostic criterion reinforcing the notion that eating disorders experienced by individuals in larger body are "less severe" /warrant less support
- Little or no incorporation of interventions specifically targeting anti-fat biases into "gold-standard" interventions and/or use of harmful, stigmatizing intervention strategies
  - Body tracing
  - "You aren't fat, you have fat"
  - Not challenging the "fat" is just a neutral description and doesn't have to come with a judgement
- Provider discomfort/avoidance of naming weight stigma in the moment with smaller bodied clients




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### What Does Recovery Look Like in a Larger Body?

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### Larger Bodied Recovery



- Living Life
- FAT JOY!

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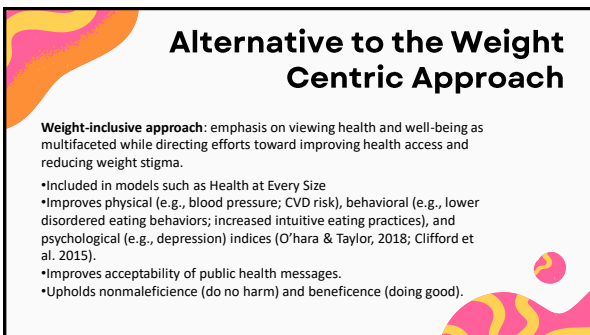
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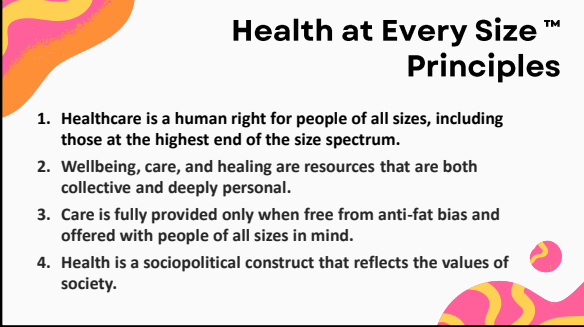
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## Health at Every Size™ Principles

1. Healthcare is a human right for people of all sizes, including those at the highest end of the size spectrum.
2. Wellbeing, care, and healing are resources that are both collective and deeply personal.
3. Care is fully provided only when free from anti-fat bias and offered with people of all sizes in mind.
4. Health is a sociopolitical construct that reflects the values of society.

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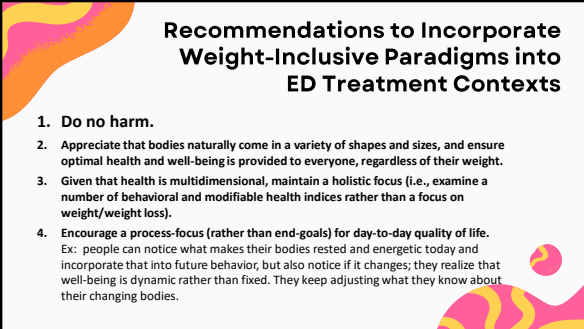
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## Recommendations to Incorporate Weight-Inclusive Paradigms into ED Treatment Contexts

1. Do no harm.
2. Appreciate that bodies naturally come in a variety of shapes and sizes, and ensure optimal health and well-being is provided to everyone, regardless of their weight.
3. Given that health is multidimensional, maintain a holistic focus (i.e., examine a number of behavioral and modifiable health indices rather than a focus on weight/weight loss).
4. Encourage a process-focus (rather than end-goals) for day-to-day quality of life.  
Ex: people can notice what makes their bodies rested and energetic today and incorporate that into future behavior, but also notice if it changes; they realize that well-being is dynamic rather than fixed. They keep adjusting what they know about their changing bodies.

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## Recommendations to Incorporate Weight-Inclusive Paradigms into ED Treatment Contexts

1. Critically evaluate the empirical evidence for weight loss treatments and incorporate sustainable, empirically supported practices into prevention and treatment efforts, calling for more research where the evidence is weak or absent.
2. Create healthful, individualized practices and environments that are sustainable (e.g., regular pleasurable exercise, regular intake of foods high in nutrients, adequate sleep and rest, adequate hydration). Where possible, work with families, schools, and communities to provide safe physical activity resources and ways to improve access to food.
3. Where possible, work to increase health access, autonomy, and social justice for all individuals along the entire weight spectrum. Trust that people move toward greater health when given access to stigma-free health care and opportunities (e.g., gyms with equipment for people of all sizes; trainers who focus on increments in strength, flexibility and pleasure rather than weight and weight loss).

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## What is Your Role as an ED Provider When A Client Expresses a Goal of Weight Loss?

1. Meet them where they are.
2. Be clear about your boundaries around how you work (your values).
3. Respect body autonomy while holding gentle boundaries.
4. Informed consent
5. Exploring the why
6. Share evidence that weight loss is more likely to lead to higher weight over time.
7. Clients may not be ready for a weight-inclusive paradigm
8. Many/Most - especially individuals in larger-bodied individual, may initially be seeking weight loss to escape/avoid the oppression of a fat body experienced within the dominant culture

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## Suggestions for Where to Begin

It's mostly about you.

1. Examination of values.
2. Acknowledge internalized biases and do training to unlearn and learn.
3. Learn about a weight inclusive paradigm including the built environment.
4. Examine how you practice & market yourself (weight normative vs weight inclusive or HAES).
5. Question further the incongruencies of the paradigms
6. Build in mechanisms to increase accountability for yourself and your colleagues to acknowledge and actively work to mitigate the influence of weight stigma within ED treatment
7. We've all done harm and we are capable of doing better.

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## Resources

**Increase awareness of your implicit bias:**


- Project Implicit - Harvard's Implicit Association Test (<https://implicit.harvard.edu/implicit/takeatest.html>)

**Professional Organizations focused on Weight Inclusivity**

- Weight Stigma Awareness Week (<https://weightstigmaawarenessweek.org/>)
- Association for Size Diversity and Health (<https://size.org/about-us/>)
- National Association to Advance Fat Acceptance (<http://naafa.net/>)
- Council on Size and Weight Discrimination (<https://cswd.org/>)
- Project Heal (<https://www.projectheal.org/>)
- The National Alliance for Eating Disorders ([www.allianceforeatingdisorders.org](http://www.allianceforeatingdisorders.org))

**Recommended Readings/Reading lists:**

Fearing the Black Body: The Racial Origins of Fat Phobia by Sabrina Strings  
 Binge Eating Disorder: The Journey to Recovery & Beyond by Amy Perching & Cheyenne Turner  
 What We Don't Talk About When We Talk About Fat by Aubrey Gordon  
 The Body is Not an Apology by Sonya Renee Taylor  
 Fat Activism: A Radical Social Movement by Charlotte Cooper  
 Hunger by Roxane Gay  
 The Salt of the Earth: The Politics of Anti-Fatness as Anti-Blackness by Dr'Shaun Harrison  
 Why It's OK to Be Fat: Dr. Reihna Nath  
 Never Satisfied: A Cultural History of Diets, Fantasies, and Fat by Hibel Schwartz  
 You Just Need to Lose Weight and 19 Other Myths About Fat People by Aubrey Gordon  
 Body Respect by Lindo Bacon and Lucy Aphramor  
 Aubrey Gordon (WTF Friend) - A Fat Reading List (<https://www.yourfatfriend.com/fat-reading-list>)  
 Althia McCaughy: Black and Embodied - Books on Eating Disorders and Body Image




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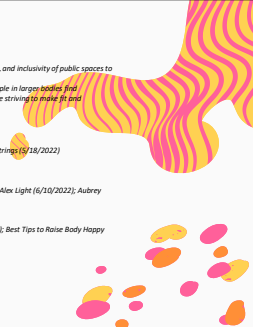
## Resources

**Apps**

- AIIC - a review app for larger-bodied individuals to rate the comfort, accessibility, and inclusivity of public spaces to help others who may be interested in going know what to expect.
- Friendly Like Me - a relatively new app to help individuals with disabilities and people in larger bodies find businesses that offer services to the public (e.g. theaters, restaurants, etc.) that are striving to make fat and accessibility a priority.

**Podcasts:**

- The Maintenance Phase
- Full Bloom: What does body-positive adolescent healthcare look like? (5/11/2022)
- Getting Curious with JW: How F\*\*\*\* Up in Fatphobia? With Professor Sabrina Strings (9/18/2022)
- Body Trust
- She's All Fat: A Fat Positive Podcast
- WetBitch with Jamecia Jamil
  - Aubrey Gordon & Michael Hobbes (1/21/2022); It's Okay to Gain Weight with Alex Light (6/10/2022); Aubrey Gordon Returns (1/20/2022)
- Wax Conversations: The racist origins of fat phobia (6/16/2022)
- What The Actual Fork
  - The Evolution of Body Positivity, Fat Liberation, and Fat Acceptance (8/5/2022); Best Tips to Raise Body Happy Kids (8/26/2022)
- Sounds Like A Cult: The Cult of Diet Culture (1/10/2023)
- Food Psych Podcasts with Christy Harrison
- Rebel Eaters Club
- Life Kit: Pushing Back Against Anti-Fatness (1/17/23)
- Unlocking Us Podcast: The body is not an apology (8/16/2020)




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## Resources

**Blogs/Substacks**

- Your Fat Friend Aubrey Gordon (<https://www.yourfatfriend.com/>)
- Burnt Toast by Virginia Sale-Smith (<https://virginiasalesmith.substack.com/>)
- Weight & Health Substack by Regan Okastin (<https://www.reganokastin.substack.com/>)




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