Health at Every Size Info Kit

Info Kit Contents

Source: Jon Robison

Foundations of HAES

While specific approaches within the Health at Every Size model will vary depending on the source, the philosophy and emphasis are very similar across the board.

The basic conceptual framework includes acknowledgment of:

1. The natural diversity in 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

Overall, HAES supports a holistic view of health that promotes "feeling good about oneself, eating well in a natural, relaxed way, and being comfortably active.

The table below contrasts the differences between Traditional Weight Loss versus Health at Every Size

Traditional Weight Loss	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 eating problems. Health and happiness are not dependent on weight status and involve a dynamic interaction among mental, social, spiritual, and physical considerations

Source: Jon Robison

HEALTH AT EVERY SIZE (HAES)

Despite the overwhelming agreement on the failure of diets to promote lasting change and growing evidence of potentially dangerous physical and psychological consequences, weight-related research and intervention continue to focus on the promotion of weight loss through dietary restriction. Despite the fact that almost all individuals following weight-loss programs will regain the weight within 5 years, and an epidemic of dangerous eating disorders, people continue to spend billions of dollars yearly on weight-loss products and services.

Our culture's unrelenting obsession with thinness has created a pervasive prejudice that causes tremendous suffering and social isolation for individuals of size. This is particularly damaging for young girls and women who are continually pressured to divert significant proportions of their energy and resources to the pursuit of ideals of body shape and size that are, for the vast majority, neither achievable nor healthy. Both men and women suffer by participating in a culture that defines the worth of the population in terms of physical appearance, rather than by the recognition of truly meaningful qualities such as honesty, compassion and love.

This unrelenting pressure to be thin is driven by diet, fashion, cosmetic, fitness and pharmaceutical industries that reap tremendous financial rewards by promoting unattainable expectations. In addition, many obesity researchers have economic links to this "diet-pharmaceutical-industrial complex", creating powerful incentives for maintaining the status quo and contributing to questionable objectivity in the reporting of research findings.

Health At Every Size, offers an alternative. This approach encourages self-acceptance by honoring the natural diversity in body shape and size and by exposing societal prejudice and discrimination against larger individuals. It promotes the benefits of physical activity by encouraging social, pleasure-directed movement. Finally, it helps people to re-connect eating to internally-directed hunger, appetite and satiety cues, leading to a more normal, peaceful relationship with food.

By breaking the endless cycle of weight loss and regain, this approach can help to stop the waste of valuable resources that results from our cultural obsession with thinness. The goal is to help people make positive changes to 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 healthy fulfilled lives by honoring and caring for the bodies they already have.

For More information contact the Wellness Education Centre
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Source: Jon Robison

HAES: Basic Premise & Tenets

Premise

Health at Every Size is based on the simple premise that the best way to improve health is to honor your body. It supports people in adopting health habits for the sake of health and well-being (rather than weight control). Health at Every Size encourages:

- Accepting and respecting the natural diversity of body sizes and shapes.
- Eating in a flexible manner that values pleasure and honors internal cues of hunger, satiety, and appetite.
- Finding the joy in moving one's body and becoming more physically vital.

Health at Every Size means:

1. **Health enhancement**
   Attention to emotional, physical and spiritual well-being, without focus on weight loss or achieving a specific "ideal weight"
- **Size and self-acceptance**
  Respect and appreciation for the wonderful diversity of body shapes and sizes (including our own!), rather than the pursuit of an idealized weight or shape
- **The pleasure of eating well**
  Eating based on internal cues of hunger, satiety, and appetite, rather than on external food plans or diets
- **The joy of movement**
  Encouraging all physical activities for the associated pleasure and health benefits, rather than following a specific routine of regimented exercise for the primary purpose of weight loss
- **An end to weight bias**
  Recognition that body shape, size and/or weight are not evidence of any particular way of eating, level of physical activity, personality, psychological issue or moral character; confirmation that there is beauty and worth in EVERY body

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Celebrate size diversity.

There is no "ideal" body.

Good health is NOT defined by body size.

Self-esteem and body image are strongly linked**.**

A healthy lifestyle can improve health risks, regardless of weight status.

Source: Jon Robison

Healthy Weight Redefined

Traditional approaches to conceptualizing weight and treating weight-related concerns have not led to improved health or decreased the rate of weight gain within American society. The hypothesis that large people are inherently unhealthy while small people are inherently healthy is NOT supported. Due to inconsistencies and lack of scientific evidence, current conceptualization of healthy or ideal weight as defined by height/weight tables, BMI's, etc. should be abandoned. In their place, a new working definition is suggested: Health At Every Size context:

HEALTHY WEIGHT = The weight at which a person's body settles as they move towards a more balanced lifestyle.

This definition *does not* suggest that all people are currently at a weight that is ideal for their health. What it supports is that movement towards a healthier lifestyle will, for most people, produce a weight that is appropriate for that person. Focusing on weight, rather than health, is most likely to result in weight cycling and over time, increased weight. Although this approach may seem extreme to some, it is actually quite congruent with the conclusion statement of the 1992 National Institutes of Health Consensus Conference 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."

The focus therefore shifts from weight to health. This could certainly include work involving physically activity and facilitating movement towards healthy, unrestrained eating. However, it is essential to also consider all the factors that contribute to whether a person is healthy or not, including social, emotional and spiritual as well as physical factors.

Many individuals who follow this path will end up with "healthy" weights that fall into categories currently defined as "obese" by both medical and social standards. Therefore, helping individuals with Self- and Size-Acceptance concerns is of paramount importance as well.

Source: Jon Robison

Obsession with Thinness

As a result of the obsession with thinness in this country, people, particularly women, are constantly being pressured to engage in weight loss practices that have no demonstrated efficacy. The failure to produce sustained weight loss is not, however, the only disturbing consequence of this obsession. Chronic dieters "must learn to not eat when hungry and to terminate eating in response to arbitrary signals that occur well before satiety." With each new diet regimen, a new set of externally imposed rules and regulations determines the amount, type and combination of foods that should and should not be eaten. Over time, this chronic disuse of innate hunger and satiety signals results in the inability to use normal physiological cues to guide food intake. Studies show that restricting food intake to lose weight results in a variety of problems, including preoccupation with food and eating, bingeing, and over time, weight gain.

Additionally, the arbitrary rules and regulations accompanying these dietary interventions often lead to an elaborate "morality" involving "good" foods (fruits and vegetables, whole grains, etc.) and "bad" foods (fats, simple sugars, etc.) and feelings of virtuosity and guilt related to eating. This "diet mentality" has contributed to greatly increased anxiety and disordered eating in the general population. The prestigious Tufts University Diet and Nutrition Letter recently commented on the dangers of this trend, 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. (For example)-Two out of 10 Americans are even under the false belief that all fat should be eliminated from the diet.*

Many leading obesity and eating disorder researchers have suggested that heightened concerns about body shape and weight and the resulting epidemic of dieting have contributed to the increased incidence of dangerous eating disorders including anorexia and bulimia nervosa. Research indicates that negative eating attitudes and behaviors are widespread and strongly ingrained by adolescence and that bingeing is commonplace among females by the age of 10. Additionally, clinical and laboratory research indicates that bulimia is almost always triggered by dieting.

Finally, 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 recent survey in Psychology Today involving more than 3,400 women in their 30s and 40s, with an average weight of 140 pounds, is illustrative of the problem. Among the findings, 24% of the women said they would give up more than three years of their lives to lose weight, 35% considered pregnancy a major source of body hatred, and 50% 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

Source: Jon Robison

inadequacy." A substantial body of literature supports this extreme body dissatisfaction as a "normative discontent" in our culture, especially among young women.

Following is a partial list of the likely consequences of the continuing obsession with thinness; potentially grave consequences that are all too rarely discussed:

Consequences of the Obsession with Thinness

- anorexia nervosa
- bulimia
- binge eating
- disordered eating and exercise behavior
- increasing rates of smoking in young girls
- body hatred
- heart valve damage
- leaky stools
- exportation of ineffective and potentially dangerous interventions to other countries

What some health professionals are doing, despite the best of intentions, IS NOT HELPING PEOPLE TO BE HEALTHIER!! Until such time when we have safe, effective, long-term interventions for weight loss, we must focus on helping people to be healthier by creating more balance in their lives, trusting that the body knows how much it ought to eat and what it ought to weigh. To do anything else, in the face of what we know to date about traditional interventions is unscientific, uncompassionate and unethical!

Source: Jon Robison

Set-Point Theory

- According to the set-point theory, there is a control system built into every person dictating how much fat he or she should carry – a kind of thermostat for body fat. Some individuals have a high setting, others have a low one. According to this theory, body fat percentage and body weight are matters of internal controls that are set differently in different people.
- The set-point theory was originally developed in 1982 by Bennett and Gurin to explain why repeated dieting is unsuccessful in producing long-term change in body weight or shape. Going on a weight-loss diet is an attempt to overpower the set point, and the set point is a seemingly tireless opponent to the dieter.
- The ideal approach to weight control would be a safe method that lowers or raises the set point rather than simply resisting it. So far no one knows for sure how to change the set point, but some theories exist. Of these, regular exercise is the most promising: a sustained increase in physical activity seems to lower the setting (Wilmore et al. 1999).
- According to the set-point theory, the set point itself keeps weight fairly constant, presumably because it has more accurate information about the body's fat stores than the conscious mind can obtain. At the same time, this system pressures the conscious mind to change behavior, producing feelings of hunger or satiety. Studies show that a person's weight at the set point is optimal for efficient activity and a stable, optimistic mood. When the set point is driven too low, depression and lethargy may set in as a way of slowing the person down and reducing the number of calories expended.
- The set point, it would appear, is very good at supervising fat storage, but it cannot tell the difference between dieting and starvation. The dieter who begins a diet with a high set point experiences constant hunger, presumably as part of her body's attempt to restore the status quo. Even dedicated dieters often find that they cannot lose as much weight as they would like. After an initial, relatively quick loss, dieters often become stuck at a plateau and then lose weight at a much slower rate, although they remain as hungry as ever.
- Dieting research demonstrates that the body has more than one way to defend its fat stores. Long-term caloric deprivation, in a way that is not clear, acts as a signal for the body to turn down its metabolic rate. Calories are burned more slowly, so that even a meager diet almost suffices to maintain weight. The body reacts to stringent dieting as thought famine has set in. Within a day or two after semi-starvation begins, the metabolic machinery shifts to a cautious `regimen designed to conserve the calories it already has on board. Because of this innate biological response, dieting becomes progressively less effective, and (as generations of dieters have observed) a plateau is reached at which further weight loss seems all but impossible.

Source: Jon Robison

Size Acceptance

The most important component of the new paradigm approach is self and size acceptance. Self-acceptance is not a denial of the importance of self-care but is rather an affirmation that, just as human worth is not based on race, class, or ethnicity; it also is not dependent on body weight, shape, or size. One size does not fit all. Our obsession with thinness has created what may be the last acceptable prejudice against individuals who do not live up to our unrealistic cultural standards. Like racism, sexism, antisemitism, and homophobia, this weightism:

"is based on visible cues, i.e., the fat person is discriminated against primarily because of the way she looks . . . defines an entire group of people numbering in the millions within a narrow range of negative characteristics and behaviors . . . elevates the status of one group of people at the expense of another . . . and serves as a vehicle for the bigot's own anxieties, frustrations and resentment."

The result of this prejudice is rampant social, economic, and educational discrimination against larger individuals. As with all forms of prejudice, however, it is not only the persecuted group that suffers. Women of all sizes suffer from an intense fear of fat that erodes with their body image and self-esteem and promotes disordered eating and exercise behavior. Men suffer as well, "by participating in a culture that defines the worth of more than one-half the population in terms of physical appearance, rather than by the recognition of truly meaningful qualities such as honesty, compassion and love." In recent years, men have also become a bigger target of the media and society's discrimination. Men's self-esteem and self-worth is now being tied to the size of their biceps, or conversely, their body fat percentage in a manner similar to women's.

As we strive to honor diversity in other areas, size-acceptance must also be encouraged by honoring the natural diversity in the human form and by more effectively challenging cultural weight prejudice.

Kratina, King, and Hayes discuss the importance of self-acceptance in their book *Moving Away from Diets: New Ways to Heal Eating Problems and Eating Resistance*. Trusting internal signals and feeling good about one's body is important for four main reasons:

1. With self-acceptance the mind and body can really connect, which is a critical component of overall health.
2. It is difficult for clients with body dissatisfaction/body hatred to take good care of themselves.
3. People need to care about themselves to want what is best for their health, and self-care is necessary for health and well-being.
4. Without a sense of peace, for example when people are constantly degrading themselves for their size/habits, making healthy choices is extremely difficult.

Source: Jon Robison

The Challenges Facing Weight-Related Research

Two major methodological challenges faced by weight-related research:

1. Body weight is determined by multiple factors including genetic, cultural, socioeconomic, behavioral, and situational mechanisms; therefore, determining the independent contribution of each variable may not be possible.
2. Study findings are difficult to generalize since location of a bias free representative sample may not be possible.

- The vast majority of individuals in America have dieted for weight loss at some point, and dieting via caloric restriction leads to lasting effects on physiological and mental functioning.
- To date, known populations of non-dieters have not been studied so it is difficult if not impossible to separate the influence of high BMI verses dieting within study results.

Ethical Concerns Associated with Weight-Related Research

1. Results of weight-related research funded primarily by commercial weight loss and pharmaceutical firms must be considered with great caution.

- These businesses represent major constituents of the 30 billion dollar per year weight loss industry and the potential risk of conflicts in interest is clear.
- The American Foundation Roundtable on Healthy Weight was convened to examine the rising incidence of overweight in America and base suggestions on a thorough review of the available scientific data. This project was funded by Weight Watchers international. In one section, the anti-diet movement was called a communication challenge to be overcome and many research studies refuting the existence of a relationship between adverse health consequences and obesity were not discussed.

2. Throughout the history of research examining the relationship between weight and morbidity/mortality, there has been considerable over-emphasis on the association between the risks of higher BMI with increasing morbidity/mortality.

- Minimizing adverse findings related to low weight is common and usually occurs either by selective omission of discussion on underweight or selective emphasis on overweight.[10]
- Some reports actually downplay the risk associated with low body weight.

Source: Jon Robison

The Concept of Ideal Weight

Height/Weight Tables

Height/weight tables have influenced conceptualization of the terms weight, overweight, and obesity since their development by Louis Dublin in his work for Metropolitan Life during the early 1940's. Unfortunately, these tables do not provide a valid representation of the relationship between weight and health:

1. Dublin reviewed insurance data and found that policy holders who weighed the least had the lowest mortality. Additionally, a majority of these individuals were also in their twenties!
2. For each height, a 30-40 pound weight range was associated with low morbidity/mortality. Dublin accounted for this discrepancy through the *arbitrary* development of small, medium, and large frame sizes.
3. *No research confirming a statistically significant linear relationship between weight and health among this population was ever conducted.*
4. The height/weight tables have been revised, but these revisions are not consistent with the 1979 Build Study upon which they are based.[2]
5. Traditionally, overweight and obesity have been defined as steps along the weight continuum established by the height/weight tables:[3]
    - Overweight: 10-19% over ideal weight for height
    - Mild obesity: 20-39% over ideal weight for height
    - Moderate obesity: 40-99% over ideal weight for height
    - Severe obesity: >100% over ideal weight for height

Body Mass Index (BMI)

- BMI is perhaps the most common criterion used for determining "healthy" weight and is defined as weight in kilograms divided by height in meters squared.[4]
- Individuals with BMIs of 25 to 29.9 are considered to be overweight and and those with BMI's of 30 and above are considered obese.[10]
- BMIs for adults ranging from 19 to 28 have been reported as desirable by various sources. This wide range depicts the ongoing debate as to the BMI level reflective of the lowest health risk as well as the rate of increased risk associated with rising BMI.[5,6,7]
- More accurate population studies are needed to better define the concepts of healthy and excess weight which may well vary according to age, gender, ethnicity, genetics, and lifestyle.[8,9]

Source: Jon Robison

The Evidence Related to Weight and Health

Even though C. Everett Koop, the former Surgeon's General, has declared obesity a disease and cause of significant morbidity/mortality within the United States, three decades of research have not supported such a clear causal link. It has been noted that fat distribution and BMI explain only about 9-13% of the variance in cardiovascular risk factors. Further, research findings are diverse, revealing that the nature of the relationship between weight and morbidity/mortality remains unknown. While it does appear that some health risk exist at both extremes of BMI, concluding that increased weight is a major component of cardiovascular risk seems premature given the lack of valid scientific evidence appropriate for general application to the American public.

The following summarizes the contradictory nature of the available weight-related literature by specific disease entity. It is suggested that readers consider the following tables, then review the listed references and make an independent, but informed decision regarding the evidence upon which interventions for clients with weight-related concerns are currently based.

The Relationship between Weight & All-Cause Morbidity/Mortality

The Relationship between Weight & All-Cause Morbidity/Mortality	
Author	Dwyer (1996)[4]
Conclusions	*Comprehensive review of literature showed a linear relationship between weight & health risk. *States disease virtually guaranteed when BMI is 2-3 times "normal".
Concern	Any risks related to low or decreasing BMI were not addressed.
Authors	Manson, Willett, Stampfer, Colditz, Hunter, Hankinson, Hennekens, & Speizer (1995)[5]
Conclusions	*A positive linear relationship between weight/mortality exists. *Statistically significant health risks for women when BMI > **27**. *Women should attempt to maintain BMI at or below **21**.
Concerns	*Confounding variables including hypertension, diabetes mellitus, hypercholesterolemia, & weight cycling were not controlled in initial data analysis. *The sample did not represent the target population (American women). *Self-reported heights/weights were used.

Source: Jon Robison

	*Increased health risk was demonstrated for BMIs over 27, but BMIs at or below 21 were recommended.
Authors	Troiano, Frongillo, Sobal, & Levitsky (1994)[6]
Conclusions	Meta-analysis of research with over 30 years of follow up: *Many longitudinal studies do **not** support a positive linear relationship between weight & adverse health risk. *Some studies demonstrate a negative relationship. *Moderately increased BMIs are not associated with increased mortality. *Weights at or slightly below current recommendations are associated with increased health risks. *A "J" shaped relationship between weight and health exists.
Concerns	*Risk associated with weight loss may be explained by smoking and/or other comorbid conditions; however, studies that controlled for these variables have not demonstrated the removal of associated health risks

The Relationship between Weight and Type 2 Diabetes

The Relationship between Weight and Type 2 Diabetes	
Authors	Manson, Willett, Stampfer, Colditz, Hunter, Hankinson, Hennekens, & Speizer (1995)[19]
Conclusion	Literature review shows high BMI is associated with increased incidence of type 2 diabetes
Concern	Caution is needed when inferring causality from statistical studies demonstrating that two variables are associated.
Authors	Pi-Sunyer (1996)[20], Porth (1994)[21], & Reaven (1988)[22]
Conclusion	*Insulin resistance is the primary pathophysiology for type 2 diabetes. *Many studies have suggested a causal relationship between increased BMI and increased insulin resistance. *Research evidence supports a relationship between increased BMI, insulin resistance & type 2 diabetes. *The prevalence of concurrent high BMI, insulin resistance, & Type 2 diabetes in study populations seems confirmatory of a causal relationship.
Concern	Do other factors such as sedentary lifestyle play a significant role in the causal pathway described above?
Author	Gaesser (1997)[23]
Conclusion	*There may be a genetic predisposition for insulin resistance for some

Source: Jon Robison

	people. *Such a genetic predisposition may be aggravated by participation in sedentary lifestyle coupled with intake of a predominantly high fat diet. *The presence of such an environmental & genetic combination may lead to development of diseases such as Type 2 diabetes secondary to the presence of insulin resistance. *The regular intake of fat & lack of physical activity may alter the genetically susceptible body's sensitivity to insulin. *It may be that the association between increased BMI & insulin resistance is nothing more than innocent co-existence.
Concern	The mere presence of two or more variables in the same individual does not infer an inherent causal relationship.

Literature Supporting the Need to Treat High BMI

Literature Supporting the Need to Treat High BMI	
Authors	Kannel, D'Agostino, & Cobb (1996)[22]
Conclusions	*Literature review supports weight reduction for BMIs >22. 6. *Review showed a positive relationship between obesity & hypertension, insulin resistance, & the ratio of total cholesterol to HDL cholesterol.
Concerns	*Study limitations are not acknowledged & the disparity between "desirable" BMIs & findings showing no significant risk for BMIs <27-30 is troubling. *Selective overemphasis on the role of BMI in predicting health risk.
Authors	Kassirer & Angell (1998)[23], Wolf & Colditz (1996)[24] , NIH (1992)[25], & Borkan, Sparrow, Wisniewski, & Vokonas (1986)[26]
Conclusions	*BMIs >30 affect health & longevity because they are associated with elevated cholesterol, hypertension, & type 2 diabetes. *Excessive weight increases the risk for gallbladder disease, gout, & cancer & may lead to osteoarthritis of the weight-bearing joints. *Benefits of weight loss for otherwise healthy mildly/moderately heavy people is unknown, but, hyperglycemia, hyperlipidemia, & hypertension are improved by a loss of 10-15% of body weight. *A causal relationship between high BMI & increased morbidity/mortality is accepted with claims that obesity raised health care costs by 6.8% in 1990.
Concerns	*Many studies in the above reviews make no attempt to control the effects of cholesterol levels, diet, activity, or weight cycling. Without evidence refuting a statistically significant role for each of these potentially confounding variables, causal assumptions about the dangers of weight are impossible.

Source: Jon Robison

	*Summarizing the research in the above manner implies that large people are inherently unhealthy due to their weight, while weight loss is possible & leads to lasting improved health, but statistical support for these implications is not provided. *The logical conclusion that health benefits will be short term because most weight loss attempts fail is ignored & the available evidence on the adverse physical, emotional, & social effects of weight loss is not provided.
Literature Questioning the Need to Treat High BMI	
Authors	Kassirer & Angell (1998)[27], Fraser (1997)[28], Gaesser (1997)[29], Robison (1997)[30], Robison, Hoerr, Petersmarck, & Anderson (1995)[31], Troiano, Frongillo, Sobal, & Levitsky (1994)[32] & Garner & Wooley (1991)[33]
Conclusions	*Reevaluation of BMI recommendations is needed. *BMI defined as moderately overweight is not related to increased mortality. *BMI at or below that recommended is associated with increased mortality. *The possibility of long-term weight loss is unproven & evidence that weight loss may be harmful exists.
Concerns	*Additional studies are needed to determine the exact role of weight in health.

Conclusions

- The scientific community is divided on the role of weight in the development of cardiovascular disease, hypertension, and all-cause morbidity/mortality.
- Well designed studies utilizing true random samples are desperately needed to clarify the true nature of the relationship between weight and health, but it is unlikely that conclusive evidence will be available soon, given the failure of over 30 years of research to end this debate.
- Despite the lack of scientific agreement within the weight/health related research, the media and many scientists, and medical professionals tend to support the concept that high BMI (termed obesity) is a disease requiring treatment and the scientific evidence that supports this opinion is frequently selectively overemphasized.

Perhaps our knowledge regarding the relationship between weight and health is best summed up by two senior editors of the prestigious New England Journal of Medicine in a 1998 editorial entitled "Losing Weight-An Ill-Fated New Year's Resolution" when they state:

"the data linking overweight and death as well as the data showing the beneficial effects of weight loss, are limited, fragmentary and often ambiguous."

Source: Jon Robison

Weight and Health – The New Evidence

The evidence surrounding weight and health continues to evolve, even today. More studies continue to emerge that emphasize the impact of other variables on health, and suggest that weight may not be as important an indicator of health as previously thought.

Edmonton Obesity Staging System: association with weight history and mortality risk

This study from Kuk et. al was published recently in 2011. It is an example of newer research that questions this weight – health link.

One main indicator highlighted by the study is the presence or absence of a medical condition. The study suggests that individuals who are classified as overweight or obese and who have a medical condition (e.g. high blood pressure, high cholesterol, high fasting blood glucose, osteoarthritis, etc.) DO have a greater risk of morbidity and mortality compared with normal weight individuals. However, individuals who are classified as overweight or obese who do not have a medical condition DO NOT have a greater risk of morbidity and mortality compared with normal weight individuals.

The study also looked at which factors put individuals at a greater risk of developing a medical condition. These factors included:

- Repeated weight loss attempts
- A low self determined weight loss goal
- Low fruit and vegetable intake
- Low level of physical fitness

Therefore, this suggests that factors such as poor physical activity and food habits, instead of the number on the scale, increases one's risk of developing a chronic condition such as heart disease and diabetes.

Source: Jon Robison

Weight and Culture: Economic, Social, and Political Issues

A North American Obsession

Our current obsession with dieting and slimness is a cultural anomaly. Throughout history, most cultures have regarded fatness as a sign of success, health, and beauty. Less than a century ago we equated body fat with affluence and higher socioeconomic status.
Excess fat was viewed as money in the body "bank"- a comfortable reserve in the case of emergencies.

Historical Evolution of the Thin Ideal: A North American Obsession

North American society is intensely preoccupied with thinness, exerting enormous pressure to conform to an extremely unrealistic "ideal" body shape and size. This unreachable standard is imposed upon children, adolescents, and adults. Although recently pressure on men to conform to unrealistic expectations has also increased, the focus of the most extreme messages and pressures continues to be on women. As a result:

- Female television characters are more likely to be thin than male characters.
- Females receive more messages from magazine articles and advertisements to stay slim and in-shape than men.
- Women directly relate physical appearance to self-esteem and are less satisfied with their body shape than men.
- Women view their bodies more aesthetically while men view their bodies in light of function and activity.
- Male ectomorphs have been rated intelligent but likely to be teased, while female ectomorphs have been considered to be more attractive and have more friends.

It is important to realize that the current American obsession with dieting and slimness is a cultural deviation. Throughout history, most cultures have regarded fatness as a sign of success, health, and beauty. Less than 100 years ago Americans equated body fat with money.

A 1908 article in Harper's Bazaar advised readers on "how to get plump," saying "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."

Though this American obsession is a relatively new one, the focus on changing women's body shape and size in order to reach some culturally-imposed ideal standard is evident as far back as the 1800s.

- Victorian era women wore corsets to achieve the hourglass figure deemed desirable for the leisure class. This style of dress was advocated by the medical establishment though it often resulted in constricted lungs, squeezed livers and bladders and dislocated stomachs.

Source: Jon Robison

- The more slender Gibson Girl of the turn of the century portrayed the physical vigor and increasing interest of women in athletics. Physicians began to see body weight as a "science" of calorie counting, "ideal weights", and weigh-ins
- The Flapper Girl of the early 1900s had a thin frame with little curvature
- After World War I, active lifestyles added another dimension. Energy and vitality became central and body fat was perceived to contribute to inefficiency and was a sign of self-indulgence
- By the 1950s, a thin woman with a large bust line (though still heavy by today's standards) was considered most attractive
- By the 1960s, slenderness was judged by women to be one of the most important determinants of physical attractiveness

In the 1950s and 1960s, full-figured women like Jane Russell, Jayne Mansfield, and Marilyn Monroe were considered ideals of feminine beauty.

Since the 1960s, a preference for slenderness also has taken hold in other Western, industrialized nations. However, due to a confluence of unique 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."

Approximately 50% of adolescents and young women are currently trying to lose weight, even though the majorities are already at or below normal weight. Research indicates that "fear of fat, restricted eating and binge eating are common among girls by age 10" and that as many as 60% of fourth and fifth graders weigh themselves every day, worry about being fat, and wish they were thinner.

Media such as television, movies, and magazines are among the most influential promoters of the thin standard, given their popularity and accessibility to the North American people. This effect is most likely to increase given continuing advances in technology and the increasing popularity and accessibility of computers and the Internet.

The Body as Machine

"Food has become an instrument of science, stripped down to a quantity of energy and deprived of all its sensual and emotional aspects."

Traditional treatment approaches to weight management view the human body 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."

Because body weight has been considered largely a mechanical matter of calories in (diet) and calories out (exercise), weight management is reduced to a measureable numeric equation and it is assumed that everyone can attain their weight goals by merely adjusting these variables.

Source: Jon Robison

The medical community's view of weight- and eating-related issues ignores the complex conditions and varying contextual factors of such issues by reducing these conditions and factors down to a single variable to be overcome. It is this premise that continues to guide medical weight management efforts

This reductionist view of food and eating to caloric input, devoid of other qualities, denies the reality of complex interaction of emotional, psychological, and cultural variables that determine voluntary food intake.

The resulting diet mentality "reinforces the split between the dieter's mind and body, and asks him/her to distrust their body, which is seen as the source of sabotage. This disconnection between mind and body can inhibit the development of intuitive eating in children and contributes to the current epidemic of adult eating disorders, disordered eating, and exercise addiction.

The Food Industry and the Media

Food Advertising and Labeling. Media messages constantly tell us that we should control both our eating and our weight. Concern about removing "undesirable" ingredients from our diet has led to product labeling that categorizes foods as "good/healthy" versus "bad/unhealthy."

Good nutrition is getting a bad name. Some 8 out of 10 Americans think foods are inherently good or bad. What this means is that a person's decision to eat a particular item has nothing to do with its context in the diet as a whole. Every bite they take represents an all-or-nothing choice either for or against good health. 2 out of 10 Americans are under the false belief that all fat should be eliminated from the diet

Our culture encourages us to "think" constantly about our food choices, and eating has become an intellectual activity 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 our choices will affect our weight and our health.

Images of Beauty. Advertising and cultural messages tell us to eliminate fat in foods. Fat on our bodies is portrayed as even worse. The media bombards women with images of female fashion models who project an emaciated, adolescent, androgynous look as the aesthetic ideal, What most women do not realize is that the published images of these models have been airbrushed to remove any flaws (such as wrinkles or visible pores in the skin), photographically elongated to maximize thinness, and in some cases generated entirely on a computer.

The content of many of the articles in women's and men's magazines is also unhelpful. 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

Source: Jon Robison

by preparing delicious recipes for loved ones, but they do not partake in these rich foods themselves.

It is interesting to note that men's health and fitness magazines now routinely feature cover images of young scantily clad, tan males with board 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.

The "Diet-Pharmaceutical-Industrial Complex"

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 ties to the diet-pharmaceutical-industrial complex, creating powerful incentives for maintaining the status quo.

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.

Medical support for thinness is one of the important developments contributing to the growth of our current obsession. It is interesting to note that only a hundred years ago, American physicians were encouraging people to gain weight, believing that " a large number of fat cells were absolutely necessary to achieve a balanced personality." As late as 1926, Dr. Woods Hutchinson, former president of the American Academy of Medicine, warned that "the longed-for slender and boyish figure is becoming a menace, not only for the present, but for future generations." Today, fatness as chronic disease and weight reduction as cure stand as almost universally accepted medical dogma."

Source: Jon Robison

WHAT REALLY HAPPENS WHEN WE DIET?

There are 26,000 diets out there and none of them work. In fact, they are often harmful. Dieting causes both physical and mental changes. Eating less than we need changes the way our body functions, as well as the way we think and feel.

While dieting, we try to ignore hunger pangs so that we can eat less than normal. Instead of listening to our body's signals, we train ourselves to eat based on other signals. This interferes with the connection between our mind and bodies.

In 1950, Ancel Keys, University of Minnesota, published the first major study on the mental effects of dieting. The study looked at 36 healthy, normal men whose food intake was restricted for 6 months. Their experiences were almost identical to experiences reported by WW II prisoners of war, patients with eating disorders and people who have taken part in weight loss programs. In today's diet obsessed culture, the results of Keys' findings are very relevant.

Food Obsession

Participants in the study thought about food all the time. They talked and daydreamed about food. They read cookbooks and collected recipes. Some reported playing with their food to make the meal last longer. Other saved food and ate it later in their rooms.

Increased Hunger

While dieting, all of the men reported increased hunger. Some were able to tolerate it but others were not. Those who broke the diet reported eating large amounts of food. We now know that dieting generally results in losing control of the amount eaten. Those who engaged in binge eating reported feelings of shame and self-loathing. Their self-esteem nose-dived.

Emotional and Personality Changes

The men experienced emotional and personality changes. Depression, bad temper, distress and anger were common to all the men.

Changes in Personal Relationships

The effects of dieting were also seen in the men's social lives. They became more withdrawn and isolated. Their relationships with women became more strained and sexual interest was drastically reduced.

Impaired Concentration

Dullness, not being able to concentrate and impaired judgment was also reported.

Most people who go on a diet will not be able to maintain their diet or their weight loss. A common reaction is to blame one's self for the failure. The Minnesota study, along with other

Source: Jon Robison

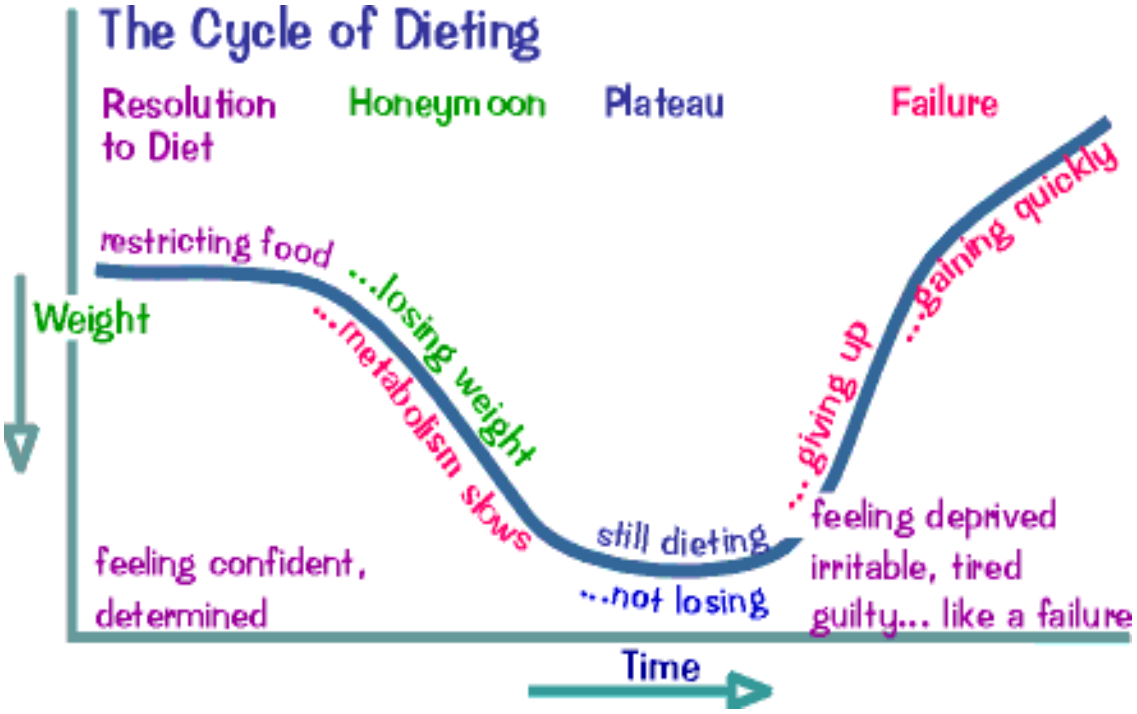
current research, shows that body weight is not easily changed. The physical and mental changes that are caused by dieting are the real reasons that diets fail.

For More information contact the Wellness Education Centre 2nd floor of the J.T. Powell Building, 519-824-4120 ext. 53327

Source: Jon Robison

THE PROBLEM WITH DIETING TO LOSE WEIGHT

- Dieting can make you feel guilty about doing something as natural as eating
- Diet plans and supplements are often lacking important nutrients needed for health
- Dieting can throw off body chemistry and fluid balance, along with energy, moods, and concentration
- In teens, dieting can cause permanent damage, such as loss of bone density
- 95% of people who lose weight by dieting gain the weight back and more!
- Repeated dieting may actually result in an elevated set-point. This means it's possible to start off in a healthy weight range and **diet your way up** to an unhealthy weight



Source: Region of Peel Public Health, (2008).

Source: Jon Robison

Body Mass Index

The most commonly used measure of an individual's weight is the body mass index (BMI). This measurement is determined by dividing the weight in kilograms by the height in meters squared (kg/m^2). Federal guidelines identify overweight as a BMI of 25.0 to 29.9 and obesity as a BMI of 30.0 above. Throughout this info kit we will be discussing the problem with these standards.

According to a report released from the Trust for America's Health, a study found that nearly two-thirds of states now have adult obesity rates above 25 percent.

But you may want to take those findings — and your next meal — with a grain of salt, because they're based on a calculation called the body mass index, or BMI.

The person who developed BMI said explicitly that it could not and should not be used to indicate the level of fatness in an individual. The BMI was introduced in the early 19th century by a Belgian named Lambert Adolphe Jacques Quetelet. He was a mathematician, not a physician. He produced the formula to give a quick and easy way to measure the degree of obesity of the general population to assist the government in allocating resources.

It is scientifically nonsensical. There is no physiological reason to square a person's height (Quetelet had to square the height to get a formula that matched the overall data. If you can't fix the data, fix the formula!). Moreover, it ignores waist size, which is a clear indicator of obesity level.

It is physiologically wrong. It makes no allowance for the relative proportions of bone, muscle and fat in the body. But bone is denser than muscle and twice as dense as fat, so a person with strong bones, good muscle tone and low fat will have a high BMI. Thus, athletes and fit, health-conscious movie stars who work out a lot tend to find themselves classified as overweight or even obese.

It gets the logic wrong. The Centre for Disease Control says on its Web site that "the BMI is a reliable indicator of body fatness for people." This is a fundamental error of logic. For example, if I tell you my birthday present is a bicycle, you can conclude that my present has wheels. That's correct logic. But it does not work the other way round. If I tell you my birthday present has wheels, you cannot conclude I got a bicycle. I could have received a car. Because of how Quetelet came up with it, if a person is fat or obese, he or she will have a high BMI. But as with my birthday present, it doesn't work the other way round. A high BMI does not mean an individual is even overweight, let alone obese. It could mean the person is fit and healthy, with very little fat.

It's bad statistics. Because the majority of people today (and in Quetelet's time) lead fairly sedentary lives and not particularly active, the formula tacitly assumes low muscle mass and high relative fat content. It applies moderately well when applied to such people because it was formulated by focusing on them. But it gives exactly the wrong answer for a large and significant section of the population, namely the lean, fit and healthy. Quetelet is also the person who came

Source: Jon Robison

up with the idea of "the average man." Averages measure entire populations and often don't apply to individuals.

It suggests there are distinct categories of underweight, ideal, overweight and obese, with sharp boundaries that hinge on a decimal place. That's total nonsense.

Continued reliance on the BMI means doctors don't feel the need to use one of the more scientifically sound methods that are available to measure obesity levels. Those alternatives cost a little bit more, but they give far more reliable results.

Source: Jon Robison

Components of HAES

The Health At Every Size (HAES) approach has 3 major components. These components are outlined in the table below

Health At Every Size: Major Components

Size and Self-acceptance: Affirmation and reinforcement of human beauty and worth irrespective of differences in weight, physical size, and shape. Acceptance of oneself and their size is seen as the cornerstone of HAES. Self-acceptance is a declaration that, just as human worth is not based on race, color, or class; it is also not dependent on body weight, shape, or size. Weightism may likely be the last culturally accepted prejudice against individuals who do not live up to our unrealistic societal standards.

Like racism, sexism, anti-Semitism, and homophobia, this weightism:
*Is based on visible cues, i.e., the fat person is discriminated against primarily because of the way the person looks… defines an entire group of people numbering in the millions within a narrow range of negative characteristics and behaviors… elevates the status of one group of people at the expense of another… and serves as a vehicle for the bigot's own anxieties, frustrations and resentments.**

***Goodman, W.C. *The Invisible Women: Confronting Weight Prejudice in America.* Carlsbad. CA"Gruze, 1995.**

This prejudice results in rampant social, economic, and educational discrimination against larger individuals.

Self-acceptance, the cornerstone of HAES, involves honoring the natural diversity in the human form and challenging current cultural weight prejudice. HAES sees self-acceptance and self-love as essential for enabling people to reach peace on issues of weight and health. Positive change is much more likely to come from self-love than self-hatred; people seek to take care of themselves when they feel they are worthy of it.

Physical activity: Support for social, pleasure-based movement for enhanced quality of life. Calorie burning and weight loss are not the goals of the activity. Physical activity is recognized as an important element in human health. Despite that, the majority of North Americans of all sizes remain sedentary. Part of the problem may lie in the old approach used to encourage people to become more active. As Thomas Moore writes:
Usually we are told how much time to spend at a certain exercise, what heart rate to aim for, and which muscle to focus on for toning… If we could loosen our grip on the mechanical view of our own bodies and the body of the world, many other possibilities might come to light.

HAES focuses on promoting movement that is social, playful, and pleasurable and includes not just jogging, cycling, and exercise classes but activities connected with everyday living such as walking and gardening. Movement is encouraged for enjoyment, camaraderie and improved quality of life, not calorie burning and/or weight loss. There is much evidence to support the notion that physical activity can positively affect health and longevity regardless of weight status

Source: Jon Robison

and recent research suggests that “if you’re fit… being 25 or even 75 pounds overweight is perfectly healthy. And if you aren’t fit, being slim gives you no protection whatsoever.”*

***Barlow, C.E., H.W. Kohl, L.W. Gibbons, and S.N. Blair. “Physical Fitness, Mortality, and Obesity 19, suppl. $ (1995): S41-44**

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 hunger and fullness cues. Diet programs use externally focused restrictive methods that rarely, if ever, help people become healthy eaters. There is much evidence to suggest that human beings are capable of regulating their hunger, satiety, and appetite signals. Food restriction, such as dieting interferes with these processes, actually increasing the likelihood of overeating.

The HAES model abolishes the concept of ‘good’ and ‘bad’ foods and instead, promotes a focus away from externally-focused eating strategies such as calorie and fat-gram counting. Instead HAES encourages relearning how to eat in response to their hunger, satiety, and appetite signals by listening to and trusting their bodily signals that indicate what, when and how much to eat.

Those who adopt normalized eating may or may not see changes in their weight. But by adopting this eating style individuals are likely to improve their health by reducing the anxiety, guilt, preoccupation with food, bingeing, weight cycling, and weight gain commonly associated with restricted eating (dieting). While more research is needed to confirm this hypothesis, initial research is in support of this conclusion.

HAES also recognizes that struggles with food-and weight-related issues can often indicate that there are deeper problems (such as low self-esteem, fear of failure, and a need for control) that cannot be resolved by merely delivering nutritional information and advice.

Source: Jon Robison

Accept Your Wonderful Self

Size and Self-Acceptance for Achieving Healthy Weight

If we let ourselves, we may start to believe that magazine cover girls (whose photos are air-brushed and trimmed in, mind you!) are the norm and that the rest of us are somehow deeply flawed. What we get then is the soundtrack "I hate myself" or "I hate what I see in the mirror" playing over and over again in our heads, fueling our endless dieting cycles and painful frustration.

"If you are caught up in not liking yourself because of your size, it quickly starts whittling away at your motivation," says Marsha Hudnall, MS, RD, Green Mountain's program director. "That inner voice makes you feel helpless and hopeless."

Self-Acceptance: The Key to Achieving a Healthy Weight

If we are to have any measure of success, it is crucial that we permanently press stop on that soundtrack and work to genuinely accept our sizes and, by extension, ourselves. Hudnall, who has more than 20 years' experience in the weight management field, knows this can be a tough sell for women with lifetime struggles with weight. But she's not suggesting that size acceptance means denying the importance of healthy weights.

Denial is not acceptance. Rather, self-acceptance means adopting a non-judgmental attitude toward yourself. It's the ability to see things as they are in the moment without harmful, self-critical voices interrupting your view of yourself. Hudnall has seen it again and again in women who come to Green Mountain: Self-acceptance is instrumental to reaching your healthy, natural weight. "Size-acceptance means focusing on the things you like about yourself while working to modify what you don't like," she says.

For women who have been listening to the self-disgust soundtrack forever, size acceptance is also pretty scary. Does accepting yourself the way you are imply that change may be impossible? Mimi Francis, the behavioral health therapist at Green Mountain, has a simple response to those doubts. It should resonate even with the most diet-savvy cynics. "How well has not liking yourself worked so far?" she asks. The truth is, it hasn't. In fact, if you dislike your body, it's that much easier to abuse it.

So the aim then is to get your attitude to work for you, not against you. Self-acceptance means acknowledging where you are now, and not repeating the mantra "I'll like my body when…" or "If only I looked like...." One helpful definition comes from Annette Colby, RD, author of *Eating Peacefully*, an online newsletter. She suggests that self-acceptance means unconditional appreciation and support for who you are now, *including* all the elements that you want to change.

Source: Jon Robison

Silencing Your Inner Critic

This view of self-acceptance respects the diversity of healthy, beautiful bodies, rather than the pursuit of an idealized weight that may come at dangerously high physical and emotional costs. The pursuit of the impossible, all the while disparaging the actual, is one of the most formidable stumbling blocks we put in our way. The self-critical reflex is a difficult one to subdue. But silencing it is a crucial component to living a healthy, fulfilling life, and attaining healthy weight and fitness goals.

Here are a few questions — some from Colby's newsletter, some from behavioral classes here at Green Mountain — to really think about on your way to increasing your own self and size acceptance.

- What are some of the feel-good things you can do now for your body? Make a list of what you enjoy. Walking, swimming, taking your kids to the park, getting a massage or manicure are all possibilities. By nurturing your body as it is now, you can begin to feel comfortable with yourself.
- What is the most positive reason for accepting your body? What is scariest?
- Where is your idea of the "perfect body" coming from? What does perfect mean to you?
- How would accepting your body right now affect your life? (Really imagine how your daily life would be different.)
- Try to make a list of all the things you're going to do when you lose weight. You know you have that list — hiking, going out with friends dancing, meeting someone new, buying a fabulous outfit, really treating yourself well. What does it mean to you to put all this on hold? What would it mean to do these things now?
- If you accepted your eating style and body, what could you learn about yourself?
- Go to a local mall or park and indulge in a little people watching. Find people who don't have cover girl looks but who you find attractive. What makes them look good? Is it their clothes, their attitude, smile or posture? Where does it seem like their beauty and confidence are coming from?

Start loving yourself today!

Accept Yourself Now. Self-acceptance means unconditional appreciation and support for who you are now, including all the elements that you want to change.

Source: Jon Robison