Emotional And Binge Eating, Chronic Dieting And Shame:
What Every Clinician and Educator Needs To Know

Presented by:
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OVERVIEW

- **Welcome and Introduction**
- **Identifying Eating Problems, Chronic Dieting and Weight Concerns**
- **Exploring the Diet Cycle and the Role of Shame**
- **Implementing the Attuned/Intuitive Eating Framework**
- **Understanding Emotional Eating**
- **Cultivating a Healthy Body Image**
- **Examining Attitudes Toward Body Size**
- **Introducing the Health At Every Size® Paradigm**
- **Changing the Conversation About Dieting, Food and Weight**
- **Wrap-Up**

"When hungry eat your rice, when tired close your eyes. Fools may laugh at me, but wise men will know what I mean."—Lin-Chi

RECOMMENDED RESOURCES (more at http://tiny.url/FindingCommunities)

My Books/Articles:

- The Making Peace with Food Card Deck: 59 Anti-Diet Strategies to End Chronic Dieting and Find Joy in Eating (C. Harrison and J. Matz, 2021)
- **The Body Positivity Card Deck**: *53 Strategies for Body Acceptance, Appreciation and Respect* (J. Matz and A. Pershing, 2020)
- ***Beyond a Shadow of a Diet****: The Comprehensive Guide to Treating Binge Eating Disorder, Compulsive Eating and Emotional Overeating* by J. Matz and E. Frankel (2nd edition 2014)
- ***The Diet Survivor's Handbook****: 60 Lessons in Eating, Acceptance and Self-Care* by J. Matz and E. Frankel (2006)
- ***Amanda's Big Dream*** by J. Matz (2015)
- ***Health Comes In All Sizes*****:** *The HAES approach to countering weight stigma by* J. Matz (Psychotherapy Networker 2018)
- ***It's not about the diet****: Building a healthy relationship with food* by J. Matz (Psychotherapy Networker 2015)
- ***Recipe for life****: Is attuned eating the answer to diet failure?* by J. Matz (*Psychotherapy Networker* 2011)
- ***Beyond lip service****: Confronting our prejudices against higher-weight clients* by Judith Matz (*Psychotherapy Networker*, 2014)
- ***Intuitive eating*****:** *Enjoy your food, respect your body* by J. Matz and L. Bacon (Diabetes Self-Management, 2010)
- **9 common mistakes parents make about their kid's weight** by J. Matz (The Body Is Not An Apology website, 2015).

Additional Books/Articles:

- **Body Respect:** by L. Bacon and L. Aprhamor (2014)
- ***Health At Every Size****:* by L. Bacon (2011)
- ***Intuitive Eating*** by E. Tribole and E. Resch (4th Edition – 2020)
- ***Healthy Bodies****: Teaching Kids What They Need To Know* by K. Kater (2012)
- ***Slim chance for permanent weight loss*** by E. Rothblum (Archives of Scientific Psychology, 2018).
- ***Weight science****: Evaluating the evidence for a paradigm shift* by L. Bacon and L. Aphramor (*Nutrition Journal*, 2011)
- ***The weight-inclusive versus weight-normative approach to health***: *Evaluating the evidence for prioritizing well-being over weight loss* by T. Tylka et al (*International Journal of Obesity*, 2014).
- ***Misclassification of cardiometabolic health*** ***when using body mass index categories in NHANES 2005-20012*** by A. J. Tomiyama et al (*International Journal of Obesity*, 2016)
- ***How and why weight stigma drives the obesity 'epidemic' and harms health*** by A. J. Tomiyama et al (*BMC Medicine*, 2018.)

Organizations:

- **National Eating Disorder Association** (NEDA)
- **Association for Size Diversity and Health** (ASDAH)
- **Academy for Eating Disorders** (AED), Weight Stigma and Social Justice SIG

Binge Eating Disorder

The DSM-V now includes BED as a discreet diagnosis, adding more credence to the seriousness of this eating problem. The criteria for diagnosis include:

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances

2. A sense of lack of control over eating during the episode (for example, a feeling that one cannot stop eating or control what or how much one is eating)

B. The binge-eating episodes are associated with 3 (or more) of the following:

1. Eating much more rapidly than normal

2. Eating until feeling uncomfortably full

3. Eating large amounts of food when not feeling physically hungry

4. Eating alone because of feeling embarrassed by how much one is eating

5. Feeling disgusted with oneself, depressed, or very guilty after overeating

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once a week for 3 months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior and does not occur exclusively during the course Bulimia Nervosa or Anorexia Nervosa

Disordered Eating

"….any woman who has some form of an unhealthy relationship with food and her body is a disordered eater. She may be caught in the diet–binge cycle, restricting 'forbidden' foods, feeling guilty after eating or in a semi starvation state from chronic under eating, fasting, skipping meals or over exercising."

—Debra Waterhouse (from Beyond a Shadow of a Diet, p. 11)

"Dysfunctional eating is eating in irregular and chaotic ways — dieting, fasting, bingeing, skipping meals — or it may mean consistently undereating much less or overeating much more than your body wants or needs. Dysfunctional eating is separated from its normal controls of hunger and satiety, and its normal function of nourishing the body, providing energy, health and good feelings. Instead, it is regulated by external and inappropriate internal controls and seeks to reshape the body or relieve stress."

—Frances Berg (from Beyond a Shadow of a Diet, p. 11)

Normal Eating

"Normal eating is going to the table hungry and eating until you are satisfied. It is being able to choose food you like and eat it and truly get enough of it -not just stop eating because you think you should. Normal eating is being able to give some thought to your food selection so you get nutritious food, but not being so wary and restrictive that you miss out on enjoyable food. Normal eating is giving yourself permission to eat sometimes because you are happy, sad or bored, or just because it feels good. Normal eating is mostly three meals a day, or four or five, or it can be choosing to munch along the way. It is leaving some cookies on the plate because you know you can have some again tomorrow, or it is eating more now because they taste so wonderful. Normal eating is overeating at times, feeling stuffed and uncomfortable. And it can be undereating at times and wishing you had more. Normal eating is trusting your body to make up for your mistakes in eating. Normal eating takes up some of your time and attention, but keeps its place as only one important area of your life. In short, normal eating is flexible. It varies in response to your hunger, your schedule, your proximity to food and your feelings."

—Ellen Satter (www.ellynsatterinstitute.org)

"…a healthy relationship with food means eating in response to physical hunger most of the time. However, normal eating can also include experiences such as eating occasionally because something looks good, eating past fullness at a special meal, eating in response to an emotion once in awhile, or choosing foods based on nutritional content because this feels caretaking. Attuned eating means that eating for satisfaction is predominant, and experiencing deprivation is virtually non-existent. Attuned eating is a natural skill. It can be relearned by people who have lost touch with their hunger and can be reinforced and nurtured with children so that they maintain this healthy relationship with food throughout their lives."

—Judith Matz and Ellen Frankel (Beyond a Shadow of a Diet, p. 281-282)

Disordered Eating Behaviors – Screening Questionnaire (DEB-SQ)

	Always	Often	Some times	Rarely	Never
1. Do you eat when you are hungry & then quit when you are satisfied?					
2. Do you spend a lot of time thinking about food?					
3. Do you eat much more rapidly than most people do?					
4. Do you eat until the point of feeling uncomfortably full?					
5. Do you tend to eat a lot of food in a short amount of time?					
6. Do you prefer to eat alone?					
7. When you are upset, do you tend to eat more or less than usual?					
8. After eating large amounts of food, do you feel disgusted or guilty?					
9. Do you tend to feel out of control while eating?					
10. Once you begin eating, do you have a hard time stopping?					
11. Do you eat large amounts even when you are not physically hungry?					
12. Do you tend to be secretive about the amounts of food you eat?					
13. Do you skip meals in order to control your weight?					
14. Do you exercise vigorously & often in order to control your weight?					
15. Do your eating behaviors interfere with your life, work or daily activities?					
16. Do your eating behaviors cause you to feel emotionally upset?					
17. Do you consider yourself a good friend?					
18. Do you feel content, for the most part, with your life at this time?					

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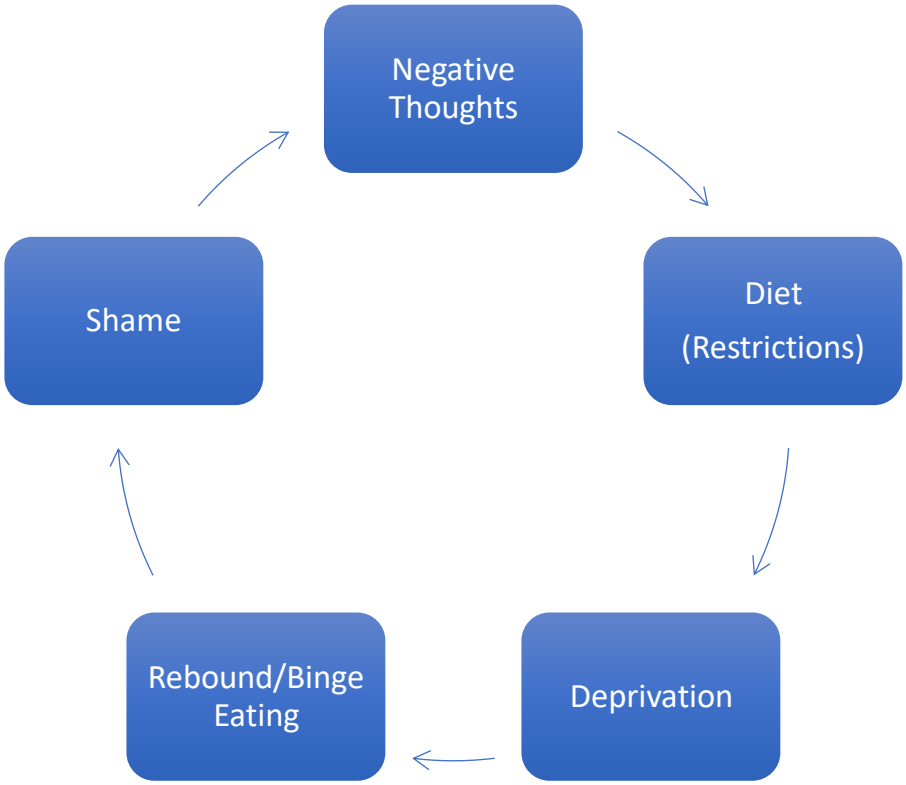
THE DIET CYCLE



Attunement: Take a moment to become attuned to your body. Notice if you are physically hungry (use the hunger scale to help you identify where you are at – you can find it in Lesson #2 of *The Diet Survivor's Handbook*.) If so, think about what would feel just right in your body, taking into consideration taste, texture, and any nutritional considerations.

Intention: Consider your intention regarding how full you want to be at the end of the eating experience. Actively think about how the food you've chosen will feel in your stomach, and decide the level of comfort you want to achieve when you finish eating - as well as 15 or 20 minutes later.

Mindfulness: Reflect on the setting you need to stay mindful of your hunger and fullness. You may find it essential to have a quiet atmosphere without distractions, or you may discover how to check in with yourself, even as you're surrounded by other people. You may enjoy some music as you eat alone, or you may even need to feed yourself in transit to make sure you get some fuel in your body. No matter what, notice the taste of your food (food tastes better when you're hungry!) and the sensations of your eating experience as you pay attention to hunger, fullness and satisfaction.

Diet Mindset	Attuned Eating
External Rules	Internal Cues
Rigidity	Flexibility
Deprivation	Satisfaction
Guilt	Pleasure
Fear	Trust
Preoccupation	Empowerment
Weight Loss	Nourishment
Shame	Compassion
Judgement	Acceptance
Constriction	Freedom
Feeling In Control	Feeling In Charge

Attuned Eating:
Feeding Yourself From The Inside Out

Judith Matz, LCSW

- *The Diet Survivor's Handbook: 60 Lessons in Eating, Acceptance and Self-Care*
- *Beyond a Shadow of a Diet: The Comprehensive Guide to Treating Binge Eating Disorder, Compulsive Eating, and Emotional Overeating*
- *Amanda's Big Dream*

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Think about the following:

- Do you know when you are hungry?
- Do you eat when you are hungry?
- Do you eat what you are hungry for?
- Do you stop when you are full?

The Three Steps of Attuned Eating:

1. Learn to recognize when you are physically hungry. This requires tuning into your stomach and noticing how it feels.
2. Identify what your body craves in response to your physical hunger. In order to match your hunger with the food that will satisfy you, have a variety of foods available and withhold judgments about what you are supposed to eat.
3. Pay attention to fullness in order to know how much to eat.

Lesson #2 (from the Diet Survivor's Handbook)
Honor your hunger. It's your body's natural way of telling you that it's time to eat.

A baby cries to let someone know that she's hungry. Her parent offers milk, and she eats until satisfied. Satisfaction is apparent by her smile and the relaxation of her body.

We are all born with the innate ability to recognize when our body needs to be fed. Yet, over time, you may have lost touch with this basic signal. Perhaps as a child you were told that it wasn't time to eat, even though you were hungry. Or perhaps as a teenager, worried about being fat, you skipped meals even though your body signaled the need for food. Maybe as an adult, you followed one of the numerous diet plans that moved you away from your body's natural hunger toward external rules about when to eat. Regardless of how you lost touch, you're now on the road to reconnecting with internal cues of hunger.

Your hunger is very important. If you ignore this signal, you become uncomfortable, experiencing headaches, weakness, fatigue, or crabbiness--all physical symptoms that let you know your needs are unmet. Furthermore, when you are extremely hungry, you will feel desperate and are at risk of overeating. Begin to tell yourself: when I am physically hungry, I will respond by eating.

At first, chances are that you'll turn to food *before* feeling hungry. This is to be expected! It will take time to learn attuned eating, so remain gentle with yourself. Check

in with your stomach often to see how it feels. Each time you reach for food, ask yourself, "Am I hungry?" If the answer is yes, tell yourself that this is wonderful and respond to your hunger by eating. This simple act will reinforce the stomach-hunger connection. If the answer is no, try to wait until you experience physical hunger. In the beginning, this will be difficult, but do not despair! Remind yourself that it will take time to follow internally based eating after so many years of dieting; look forward to the day when this becomes more natural for you. Allow yourself to eat, and then do your best to wait again for physical hunger.

By honoring your physical hunger, you'll learn that there is a way to organize your eating that's reliable and satisfying. This is the core of normalizing your relationship with food.

Activity: Identifying your physical hunger

Use the *Hunger Scale* to identify your hunger. Look for signals to let you know that you are physically hungry, such as a gnawing or empty feeling. Try to respond when you feel, "somewhat hungry" or "hungry." Remember, when you become "very hungry" or "starving" you put yourself at risk of overeating.

Starving

Very Hungry

Hungry

Somewhat Hungry

Not Hungry/Not Full

Somewhat Full

Full

Very Full

Stuffed

Tune into your stomach at this time and notice where you are on this scale. If you are hungry, it is time to eat! If you are not hungry, see if you can pay increased attention to your stomach, and get to know your own hunger cues.

"As soon as you trust yourself, you will know how to live."
Goethe

Based on *The Diet Survivor's Handbook: 60 Lessons in Eating, Acceptance and Self-Care* (2006)

Emotional and Binge Eating, Chronic Dieting and Body Shame

WRITING PROMPTS

- When I think about letting go of dieting behaviors I…
- When my client(s) think about letting go of dieting behaviors he/she/they…
- The most exciting aspect of attuned eating is…
- The biggest challenge to becoming an attuned eater is…
- The next step for me in using this framework with clients/for myself is…

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The Translation of Feelings into the Language of Food

It feels like this:

anger----------→eat

It happens like this:

anger----------→unable to tolerate uncomfortable feeling(s)----------→eat----------→yell-------→resolve to lose weight

- The use of food to manage feelings means that you have a calming problem.
- When you reach for food to calm yourself, you are making an attempt to help yourself.
- When you yell at yourself, you move further away from what is bothering you and you prolong your overeating.
- When you resolve to lose weight, you are trying to solve the wrong problem. After all, going on a diet will not fix the real problem, which is that you were having an uncomfortable feeling and could not tolerate it.
- Stay compassionate with yourself. "I'm reaching for food and I'm not hungry. Something must be bothering me," is a much more helpful when to speak to yourself than calling yourself names.

Appendix K

ASSESSING YOUR SIZE ATTITUDES

This behavior assessment can be used to evaluate your support for the health and well being of large people. Use the following scale to indicate the frequency of each behavior.

1=never 2=rarely 3=occasionally 4=frequently 5=daily

How often do you:	**Never - Daily**
1. Make negative comments about your fatness	1 2 3 4 5
2. Make negative comments about someone else's fatness	1 2 3 4 5
3. Directly or indirectly support the assumption that no one should be fat	1 2 3 4 5
4. Disapprove of fatness (in general)	1 2 3 4 5
5. Say or assume that someone is "looking good" because s/he has lost weight	1 2 3 4 5
6. Say something that presumes that a fat person(s) wants to lose weight	1 2 3 4 5
7. Say something that presumes that fat people should lose weight	1 2 3 4 5
8. Say something that presumes that fat people eat too much	1 2 3 4 5
9. Admire or approve of someone for losing weight	1 2 3 4 5
10. Disapprove of someone for gaining weight	1 2 3 4 5
11. Assume that something is wrong when someone gains weight	1 2 3 4 5
12. Admire weight loss	1 2 3 4 5
13. Admire rigidly controlled eating	1 2 3 4 5
14. Admire compulsive or excessive exercising	1 2 3 4 5
15. Tease or admonish someone about their eating (Habits/choices)	1 2 3 4 5
16. Criticize someone's eating to a third person ("so-and-so eats way too much junk")	1 2 3 4 5
17. Discuss food in terms of "good/bad"	1 2 3 4 5
18. Talk about "being good" and "being bad" in reference to eating behavior	1 2 3 4 5
19. Talk about calories (in the usual dieter's fashion)	1 2 3 4 5
20. Say something that presumes being thin is better (or more attractive) than being fat	1 2 3 4 5
21. Comment that you don't wear a certain style because "it makes you look fat"	1 2 3 4 5
22. Comment that you love certain clothing because "it makes you look thin"	1 2 3 4 5
23. Say something that presumes that fatness is unattractive	1 2 3 4 5
24. Participate in a "fat joke" by telling one or	

laughing/smiling at one

25. Support the diet industry by buying their services and/or products 1 2 3 4 5
26. Undereat and/or exercise obsessively to maintain an unnaturally low weight 1 2 3 4 5
27. Say something that presumes being fat is unhealthy 1 2 3 4 5
28. Say something that presumes that being thin is healthy 1 2 3 4 5
29. Encourage someone to let go of guilt 1 2 3 4 5
30. Encourage or admire self-acceptance and self-appreciation/love 1 2 3 4 5
31. Encourage someone to feel good about his/her body as is 1 2 3 4 5
32. Openly admire a fat person's appearance 1 2 3 4 5
33. Openly admire a fat person's character, personality, or actions 1 2 3 4 5
34. Oppose/challenge fattism verbally 1 2 3 4 5
35. Oppose/challenge fattism in writing 1 2 3 4 5
36. Challenge or voice disapproval of a "fat joke" 1 2 3 4 5
37. Challenge myths about fatness and eating 1 2 3 4 5
38. Compliment ideas, behavior, character, etc. more often than appearance 1 2 3 4 5
39. Support organizations which advance fat acceptance (with your time or money) 1 2 3 4 5

Behaviors 1-28 are unhelpful or harmful; look over areas that need improvement and strive to avoid these and similar behaviors in the future. Behaviors 29-38 help and support size acceptance; re-read items you marked "never" (1) or rarely (2); make a list of realistic goals for increasing supportive behavior.

From: Matz, J. and Frankel, E. (2004) *Beyond a Shadow of a Diet: The Comprehensive Guide to Treating Binge Eating Disorder, Compulsive Eating, and Emotional Overeating*. New York: Brunner-Routledge. Available: www.taylorandfrancis.com or www.amazon.com

The Relationship Between Health and Weight

Please mark each of the statements as true or false:

	True	False
1) *People who fall into the "overweight" BMI category live longer than those in the "normal" category.*	☐	☐
2*) Diets fail in the long-term for most people, and about one-third to two-thirds end up heavier than their pre-diet weight.*	☐	☐
3) *Feeling positive about your weight may be more important than your actual weight when it comes to your health.*	☐	☐
4) *There are approximately 54 million Americans mislabeled as unhealthy because their BMI falls in the "overweight" or "obesity" category.*	☐	☐
5*) People who are at a higher weight and are physically fit have half the mortality rate as people who are thin and not fit.*	☐	☐
6) *The obesity paradox means that being "overweight" is protective against diseases including hypertension (high blood pressure) and heart disease.*	☐	☐

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1) **TRUE:** *Examined over 3 million people and reaffirmed that people in the "overweight" category have significantly lower all-cause mortality, and people in the low end of the "obesity" category – where the majority of people in the obesity category fall – show no difference in mortality rates relative to "normal weight."*

Flegal, K. M., et al. Association of all-cause mortality with overweight and obesity using standard body mass index categories. *Journal of the American Medical Association.* 2013; 309(1) 71 – 82.

2) **TRUE:** *A comprehensive review of weight loss research found that despite initial weight loss, the vast majority regained the weight, and one-third to two-thirds ended up heavier than their pre-diet weights.*

Mann, T. et al. Medicare's search for effective obesity treatments: diets are not the answer. *American Psychology*, 2007 April 62 (3), 220 – 33.

3) **TRUE**: *Normal weight women who are unhappy with their weight have higher blood pressure and fasting glucose levels than "normal" weight women who are fine with their bodies. The same holds true for people across* ***every*** *BMI category.*

Blake, C. E., et al. Adults with greater weight satisfaction report more positive health behaviors and have better health status regardless of BMI. *Journal of Obesity*, Volume 2013 (2013).

4) **TRUE:** *Using the most reliable data from the NHANES Survey shows that 54 million Americans whose BMI classifies them as "overweight" and "obese" are in perfect health according to cardiometabolic measures, while 21 million whose BMI puts them in the normal category are unhealthy.*

Tomiyama, A. J. et al. Misclassification of cardiometabolic health when using body mass index categories in NHANES 2005 – 2012. *Journal of Obesity*, 2016.

5) **TRUE:** *Followed over 26,000 men and found that obese-fit men and lean-fit men both had low death rates and obese-fit men had death rates half that of lean, unfit men.*

Blair, S., et al. Physical fitness and all-cause mortality: A prospective study of healthy men and women. *JAMA,* 1989; 262(17) 2395-2401.

6. **TRUE***: Dozens of studies have confirmed the existence of the paradox. Being overweight is now believed to help protect patients with an increasingly long list of medical problems, including…hypertension, and heart disease.*

Brown, H. The obesity paradox: Scientists now think that being overweight can protect your health. *Quartz*, November 17, 2015 (available online)

APPENDIX B

THE TENETS OF HEALTH AT EVERY SIZE*

The Health At Every Size® (HAES) paradigm continues to gain momentum across health professions and among groups concerned with the consequences of dieting and weight stigma. Based on the increasing evidence that the number on the scale is an unreliable indicator of health, the following list of weight neutral tenets promotes healthy behaviors and attitudes to enhance the well-being of people regardless of size.

1. **Health Enhancement** – attention to emotional, physical and spiritual well- being, without focus on weight loss or achieving a specific "ideal weight."
2. **Size and self-acceptance** – respect and appreciation for the wonderful diversity of body shapes and size (including one's own!), rather than the pursuit of an idealized weight or shape.
3. **The pleasure of eating well** – eating based on internal cues of hunger, satiety, and appetite, rather than on external food plans or diets.
4. **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.
5. **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.

*Since the publication of our book, the principles of the HAES framework were updated to reflect the social justice mission of the **Association for Size Diversity and Health**:

1. **Weight Inclusivity**: Accept and respect the inherent diversity of body shapes and sizes and reject the idealizing or pathologizing of specific weights.
2. **Health Enhancement**: Support health policies that improve and equalize access to information and services, and personal practices that improve human well-being, including attention to individual physical, economic, social, spiritual, emotional, and other needs.
3. **Respectful Care**: Acknowledge our biases, and work to end weight discrimination, weight stigma, and weight bias. Provide information and services from an understanding that socio-economic status, race, gender, sexual orientation, age, and other identities impact weight stigma, and support environments that address these inequities.
4. **Eating for Well-Being**: Promote flexible, individualized eating based on hunger, satiety, nutritional needs, and pleasure, rather than any externally regulated eating plan focused on weight control.

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

3 COMMON MYTHS ABOUT THE HAES® FRAMEWORK

1) Health At Every Size means that all higher weight people can be healthy.

HAES means that people of all sizes deserve to pursue – and have equal access to - strategies and treatments that support their bodies to achieve optimal health as they define it. Health is a continuum – there are people at higher weights who are healthy and those who are not healthy, just as there are people at lower weights who are healthy and those who are not healthy.

HAES also acknowledges the role that stigma, bias, and oppression play in a person's health.

2) Health At Every Size is against weight loss.

HAES is against the *pursuit* of weight loss because of the dismal failure rate of diets and the physical and emotional harm that results. HAES encourages people to take care of their bodies – if weight changes occur it is a side effect rather than the goal. HAES does not use weight loss as a measure of success – it is a weight neutral/weight inclusive approach.

3) Health At Every Size is only relevant to people at higher weights.

HAES is an important framework for people of all sizes. At it's core, HAES is a social justice movement that seeks to end discrimination and oppression for people based on body size. HAES acknowledges that people across the weight spectrum feel the effect of weight stigma, fear of fat, and diet culture. It is a set of principles that can help people take the focus off of weight and, instead, focus on living their best life as they define it.

HAES-informed eating disorder therapists recognize that:

1) Behaviors considered eating disordered in thinner people are often prescribed to higher weight people.
2) All types of eating disorders occur in people of all shapes and sizes. At the same time, people of all shapes and sizes do not necessarily have an eating disorder.
3) Successful recovery from Binge Eating Disorder is not dependent on weight loss.

HEALTH AT EVERY SIZE (HAES®) MATTERS:
Supporting Clients In Their Journey Toward Self-Acceptance

WRITING PROMPTS

- When I think about implementing the HAES framework I…
- The most exciting part of the HAES framework is…
- The biggest obstacle I see in using the HAES framework is…
- During today's workshop I've become aware that…
- In order to use the HAES framework in my work I need to…

10 Steps to Help Your Child

Develop a Healthy Body Image

www.amandasbigdream.com

1. Avoid diet talk and dieting behavior in front of children (and altogether, if possible!)

2. Avoid commenting negatively on other people's body weight, shape and/or size, *as well as your own*, in front of children.

3. Refrain from criticizing your child's weight or appearance.

4. Do not categorize foods as "good" and "bad".

5. Feed your child and encourage physical activity using guidelines based on age, not based on body size.

6. Compliment your child on positive behaviors and characteristics, rather than focusing on body size and appearance.

7. Encourage physical activity for enjoyment and fitness, rather than weight control.

8. Promote a healthy relationship with food. This includes honoring cues for hunger and fullness, providing a wide variety of all types of food, and sharing family meals whenever possible.

9. Support self-care behaviors—rather than weight loss—as the road to happiness, health and success. Examples include getting enough sleep, good grooming habits, developing creative hobbies and interests.

10. Teach kids that people naturally come in different shapes and sizes, and that everyone deserves to be treated with respect.

EMOTIONAL AND BINGE EATING, CHRONIC DIETING AND SHAME

WHAT EVERY CLINICIAN AND EDUCATOR NEEDS TO KNOW

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1

UNDERSTANDING THE PROBLEM

2

OUR CLIENTS

- Binge Eating Disorder
- Compulsive Eating
- Chronic Dieting
- Emotional Eating
- Diet Mindset
- "I Want To Lose Weight"

3

WHAT IS BED?

- Eating more than most people would in discrete period of time
- A sense of lack of control over eating

Three of the Following:

- Eating rapidly
- Eating large amounts of food when not physically hungry
- Eating until uncomfortably full
- Eating alone because of embarrassment over eating
- Feeling disgusted, depressed, or very guilty after eating

4

CAUSES AND CO-OCCURRING MENTAL HEALTH CONDITIONS

- -Anxiety Disorders
- -Depression/Mood Disorders
- -PTSD
- -Genetic Predisposition to perfectionism, impulsivity, black/white thinking, dissociation
- -History of dieting or restrictive eating patterns
- -History of body shame and/or weight bullying

- "Problems with family or other significant relationships, significant losses, histories of emotional abuse physical neglect, and sexual abuse are more correlated with BED than other eating disorders, and considerably higher than in the general population."
- Amy Pershing, Binge Eating Disorder, p. 14.

5

WHY THE DSM V MATTERS

- Validates that BED is a "real thing."
- Insurance coverage for people seeking treatment
- NOT THE SAME AS "OBESITY"

Did you know...

Binge Eating Disorder is the most common eating disorder in the U.S.??

6

SUB-CLINICAL DISORDERED EATING PATTERNS

- Skipping meals
- Over-exercising
- Fasting
- Eliminating Food Groups (without a medical reason)
- Disconnected From Hunger/Fullness
- Eating to Discomfort
- Rigidity (Orthorexia)
- Dieting
- Guilt

7

THE CULTURAL BACKDROP

8

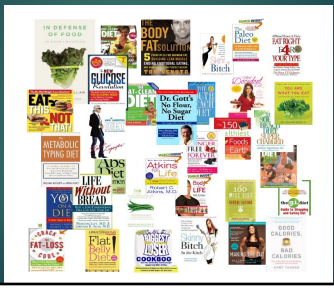
THE CULTURAL BACKDROP

9

The CULTURAL BACKDROP

10

What's New This Year?



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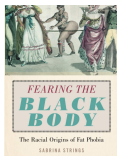
CULTURAL SUBJECTIVITY

- Agricultural versus industrial economy
- King Henry the Eighth and Oprah Winfrey effect
- Cross- Cultural Perspective
- Art museums
- Fearing The Black Body by Sabrina Strings

"Ideals, by definition, are modeled on rare qualities…if and when, by artificial methods, the majority can squeeze into the ideal, the ideal changes. If it were attainable, what good would it be?" Charisse Goodman



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VOGUE INTRODUCES TWIGGY

"Twiggy is called Twiggy because she looks as though a strong gale would snap her in two and dash her into the grounds.

13

WHAT ARE THE MESSAGES?

"Become the woman every woman hates."

14

WHAT ARE THE VALUES?

15

WHAT ARE THE CONTRADICTIONS?

16

WHAT DOES EMPOWERMENT LOOK LIKE?

17

DIET CULTURE AND THE WELLNESS INDUSTRY

"The diet industry is a virus, and viruses are smart. It has survived all these decades by adapting, but it's as dangerous as ever. In 2019, dieting presents itself as wellness and clean eating, duping modern feminists to participate under the guise of health. Wellness influencers attract sponsorships and hundreds of thousands of followers on Instagram by tying before and after selfies to inspiring narratives. Go from sluggish to vibrant, insecure to confident, foggy-brained to cleareyed. But when you have to deprive, punish and isolate yourself to look 'good' it is impossible to *feel* good. I was my sickest and loneliest when I appeared my healthiest." ——Smash the Wellness Industry, Jessica Knoll, NYTimes, June 2019

18

WHAT IS A DIET?

Any time a person manipulates food for the purpose of weight loss, they are on a diet, and subject to the same physiological and psychological pitfalls.

19

DIETING AND BED

Approximately 25 – 30% of people seeking weight loss treatments have BED!

20

DIETING TRIGGERS/SUSTAINS BINGE EATING

"Within a diet and thin-focused culture, the focus has been on weight loss as the goal. This 'treatment' is often promoted by well-intentioned friends, family, and professionals. But with binge eating, dieting is a *causal* factor in the *development* of binge eating disorder. So it's essential for treatment to provide alternatives to dieting for improving health and body image. In fact, weight loss as a *goal of treatment*—as opposed to goals of improved self care–can be damaging to the process of recovery."

(Binge Eating Disorder Association (BEDA) website)

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DEPRIVATION

The Milk Shake Study
Restrained vs. Non-Restrained Eaters


"I've blown it anyway so I might as well keep eating before I go back on my diet."

22

THE KEYS STUDY

6 month diet with adequate vitamins, minerals, protein
Lost 25% of their body weight
Underwent profound personality changes
Became irritable, lethargic, distracted, depressed, apathetic
Became obsessed with food

"The men were allowed about 1,570 calories per day…the restricted meal plan they followed was similar to diets marketed by commercial weight loss programs today."

"When the men entered the refeeding portion of the study, the food restrictions were lifted. Free to eat what they wanted, the men engaged in binge eating for weeks, yet continued to feel ravenous."

From Beyond a Shadow of a Diet (2014) p. 22

23

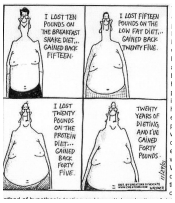
THE PINK ELEPHANT

24

WHY DIETS FAIL

- Genetics
- Evolution
- Adaptation

"A number of studies have shown the inescapable consequences of repetitious cycles of weight loss and gain appears to be even greater accumulations of fat."
Glenn Gaesser, author of Big Fat Lies



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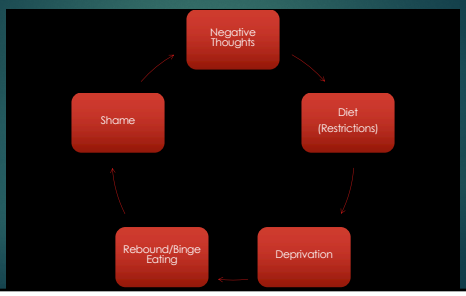
THE DIET CYCLE



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SHAME: WHAT PEOPLE SAY:

- I was bad today (referring to what they ate).
- I'm embarrassed to go out because I feel too fat.
- I've let myself go
- I'm ashamed to eat in public
- I'm ashamed to be seen in public

(from The Diet Survivor's Handbook, p. 16)

27

SHAME: WHAT PEOPLE FEEL:

- I am what I weigh; the scale determines my worth.
- I envy thin people and equate their appearance with success; my body implies failure.
- I feel "less than" because of my body size.
- If only I could lose weight and get thin, all of these negative feelings would disappear.

(from The Diet Survivor's Handbook, p. 16)

28

WHAT IS SHAME?

- Connection gives life meaning
- Shame is fear of disconnection

Is there something about me that, if people know or see it, I will not be worthy of connection.
(From Brene Brown, The Power of Vulnerability, TEDx 2010)

29

WE ALL HAVE SHAME

- Secrecy
- Silence
- Judgement

The less we talk about it, the more control it has over our lives.

I'm not _____enough.

30

SHAME CAN BE SUBTLE

button poetry

31

IMPLEMENTING TREATMENT

32

ATTUNED EATING: THE ANTIDOTE TO DIETING

- DIETING = RIGIDITY
- BINGEING = CHAOS
- ATTUNED EATING = INTEGRATION

"The river of integration represents the movement of a system across time. When the system is integrated, it is adaptive and harmonious in functioning."

Dan Siegel, The Mindful Therapist

33

The DIET MINDSET VS. ATTUNED EATING

"When hungry eat your rice, when tired close your eyes. Fools may laugh at me but wise men will know what I mean."

--Lin-Chi

34

LEARN THE STEPS OF ATTUNED EATING

- **Do you know when you're hungry?**
- **Do you eat what you're hungry for, choosing from a wide variety of foods?**
- **Do you stop eating when you're full/satisfied?**

35

WHEN

1) Starving
2) Very Hungry
3) Hungry
4) Somewhat Hungry
5) Not Hungry/Not Full
6) Somewhat Full
7) Full
8 Very Full
9) Stuffed

(From Beyond a Shadow of a Diet, 2nd edition p. 82)

36

WHAT

Hot
Cold
Crunchy
Mushy
Smooth
Salty
Spicy
Sweet
Bland
Protein
Carbohydrate
Fat

(from Beyond a Shadow of a Diet, 2nd edition, p. 90)

37

CHANGING PATTERNS

-Novelty vs. habituation
-What about "food addiction?"
-Semantics matter! What **feels** satisfying/unsatisfying in the body (vs. "I **was** good/bad.)
-Keeping food available
-Mealtimes/socializing

38

EATING STYLES

Vegetarian

Vegan

Kosher/Halal

Cultural

Health Concerns

Etc.!

39

HOW MUCH

Remember to AIM

Attunement

Intention

Mindfulness

(from Beyond a Shadow of a Diet, 2nd edition, p. 108)

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HELPFUL PHRASES

-If there's no signal to start, then there's no signal to stop.

-Food tastes better when I'm hungry.

-I'm full but not satisfied. What would have felt better in my body?

-The sooner I stop, the sooner I get to eat again!

-I can eat as much as I want. How do I want to feel when I'm done? 10-20 minutes later? How much do I think it will take to feel that way?

-If I stop now, I can have it again when I'm hungry.

-I feel too full. I'll do my best to wait until I'm hungry again.

41

WHO HAS ACCESS?

42

THE PROCESS OF ATTUNED EATING

- -Collect experiences (vs. turning into the "stomach hunger" diet.)
- -Check in about positive experiences as well as challenges.
- -Self-talk: Cultivate compassion (vs. "I blew it.")
- -Expect obstacles. Work on concrete strategies first – then dig deeper.

43

COMMON OBSTACLES

- Good/Bad Thinking (Judgment)
- Not Having Food Available
- Habitual Patterns
- Psychological Factors

44

INTUITIVE EATING VS. FLEXIBLE CONTROL

"Flexible control strategies include monitoring portion sizes, eating smaller amounts and lower calorie versions of comfort foods, staying within a predetermined daily calorie range, and self-monitoring weight. Flexible control have been touted by certain scholars as adaptive approaches to eating that stand in contrast to rigid restriction of food intake. This is the first study to compare Intuitive Eating with flexible control. Results indicate 1) Intuitive Eating was found to be related to well-being as well as a lower BMI. 2) Intuitive Eating is an adaptive and distinct construct from flexible control. 3) Flexible control was found to overlap with rigid control. The researchers concluded that flexible control eating strategies should not be adopted by health professionals or health organizations."

Tylka, T.L., et. al, (2015) Is intuitive eating the same as flexible dietary control? Their links to each other and well-being could provide an answer. Appetite 95: 166-175.

45

LIMITATIONS OF RESEARCH/ POTENTIAL RISKS

Small preliminary studies are promising.
(http://www.intuitiveeating.org/resources/studies/)

-We need testing in bigger samples.
-We need testing in diverse samples.
-Weight-centered culture makes implementation more difficult.

Attuned/intuitive eating is contraindicated in early stage of anorexia.

46

LIMITATIONS OF RESEARCH/ POTENTIAL RISKS

SMALL PRELIMINARY STUDIES ARE PROMISING
(http://www.intuitiveeating.org/resources/studies/)

- We need testing in bigger samples
- We need testing in more diverse samples
- Weight-centered culture makes implementation more difficult

CONTRAINDICATED IN EARLY STAGE OF ANOREXIA

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ATTUNED EATING LEADS TO ATTUNED LIVING

- I have needs
- My needs are specific
- My needs can be filled

48

A DIETITIAN SHARES HER JOURNEY

49

WHAT ABOUT WEIGHT LOSS?

- Empathy
- Information
- Hope

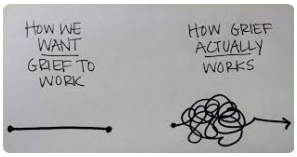
~~~~~~~~~~~~~~~~~~~~~~~~

- Pursuit of Weight Loss vs. Side Effect
- What the Research Tells Us
- Weight Neutral
- Weight Inclusive

50

RELIEF AND GRIEF

- Denial
- Anger
- Bargaining
- Depression
- Acceptance



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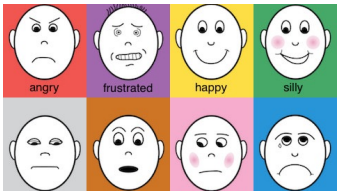
UNDERSTAND EMOTIONAL ASPECTS



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THE USE OF FOOD FOR AFFECT REGULATION

- Soothing
- Distracting
- Comforting
- Numbing
- Calming

53

THE TRANSLATION OF FEELINGS INTO THE LANGUAGE OF FOOD

- **It feels like this:**
  Anger----------→eat

It happens like this:
Anger------→unable to tolerate uncomfortable feelings------→eat------→yell------→resolve to lose weight

54

SELF-COMPASSION MATTERS!

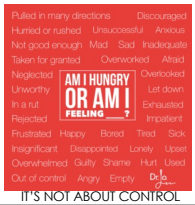
Instead of yelling at yourself for turning to food, try this:

"I'm reaching for food and I'm not hungry. Something must be bothering me."

55

WHAT AM I REALLY HUNGRY FOR?

BUILDING STRATEGIES



IT'S NOT ABOUT CONTROL

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SAMPLE MINDFULNESS PRACTICES

- **Diaphragmatic Breathing**
- **Place of Refuge**
- **Hub of Awareness**

(http://www.drdansiegel.com/resources/wheel_of_awareness/)

57

BED AND TRAUMA-INFORMED TREATMENT

Lack of willpower or disconnection from fear and shame?

Feeling heard and seen much of the time vs. exposure to physical/emotional harm, harsh judgment, and/or stigma.

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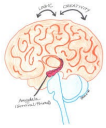
LOSS OF AUTHENTICITY

Need to be loved vs. need to be authentic

Shame becomes hardwired



Turning to food is a way to survive

Cultural message: Lose the weight to lose the shame

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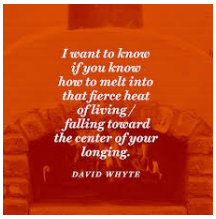
BUILDING A WINDOW OF TOLERANCE

- Move from old stories of shame and fear.
- Identify feelings and hold them with compassion and curiosity.
- Build awareness and connection to self (and others).



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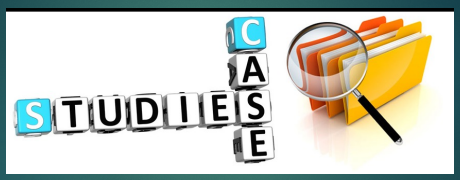

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CULTIVATING A HEALTHY BODY IMAGE
RESISTING INTERNALIZED WEIGHT STIGMA

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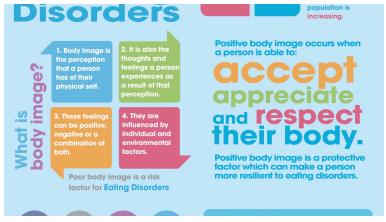
WHAT IS A HEALTHY BODY IMAGE?



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BODY IMAGE STRATEGIES

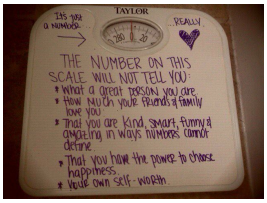
Stop Negative Talk/Practice Compassion

- **24 Hours of Bad Body Thoughts**
- **"If yelling made me thin…**
- **Computer Exercise**

64

CREATING AN ENVIRONMENT OF ACCEPTANCE

- **CLOTHES**
- **SCALES**
- **LIVING IN THE PRESENT:**
  If I were thin I would…
- **PSYCHOLOGICAL ASPECTS**



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BODY POSITIVITY AND SOCIAL MEDIA

66

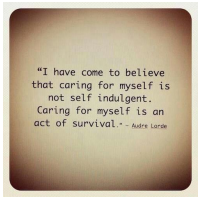
TAKING IN THE GOOD

EMBODY THE EXPERIENCE

67

THREE STEPS OF SELF-COMPASSION

- **Self-Kindness**
- **Common Humanity**
- **Mindfulness**



(Self-Compassion by Kristen Neff)

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BODY IMAGE HEALING

"Body image healing is about learning to live in relationship to your body and body image experience with skillfulness and kindness. It's about being able to unpack the wisdom that is housed in your body to access greater self-understanding and to make choices about how to take care of yourself. With body image healing, there is no 'right' or 'wrong' way to feel about your body because healing isn't about eradicating negativity. While we would all like to never feel badly about our bodies ever again, that goal is problematic and not at all possible. Our bodies don't conform to beauty standards – they get sick or injured, and they change with age. Getting 'rid of' negative body image is sort of like setting the goal to never feel sad, disappointed, grief stricken, or angry every again. It's a nice fantasy but not at all reality. Instead, this process is really about developing skills to support yourself through moments that feel painful. But as it turns out, cultivating things like insight, mindfulness, self-compassion, critical thinking skills, and a values-driven life typically helps to turn the volume down on the feelings of body hatred."

(Marci Evans, RD, *The Body Image Tour: Lessons Learned*, 2018)

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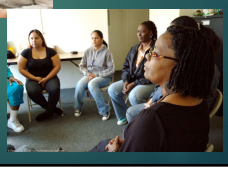
INDIVIDUAL VS. GROUP TX



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Three Questions

- How would you describe your relationship with food?
- When did you first learn that your body was a "problem?"
- If you were at the weight you think you should be, what would be different in your life?

71

FINDING SOLUTIONS

72

HOW CAN WE ENGAGE, SUPPORT, AND HELP CLIENTS TO TAKE CARE OF THEMSELVES?

73

EXAMINE YOUR OWN BELIEFS

74

THIN FAT

happy	lazy
successful	couch potato
sexy	unhealthy
exercise	stupid
healthy	miserable
confident	out of control

(from Beyond a Shadow of a Diet, 2nd edition, p. 303)

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LANAGUAGE MATTERS

- BODY MASS INDEX (BMI)
- OBESITY
- OVERWEIGHT
- HIGHER WEIGHT
- FAT
- ACE SCORE - BEHAVIORS

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TEACH THE HAES® APPROACH

- Offers a path toward optimal health – physical, emotional, and spiritual – for every body!
- Research – based
- Focus on well-being not weight
- Focus on sustainable behaviors
- Addresses social justice issues

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WEIGHT AND HEALTH

- Myth #1: Higher weights = higher mortality
- Myth #2: Higher weights = health problems
- Myth #3: The best way to live longer and healthier is to pursue weight loss through diet and exercise

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MYTH #1
WEIGHT AND MORTALITY

"Overweight" – lowest mortality

"Normal" weight and lower end of "obesity" – same risk

"Obesity" – slightly higher

"Underweight" – highest mortality

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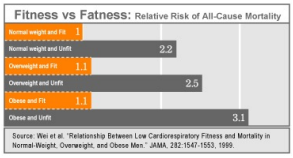
FIT AND FAT

Men who are fit/"obese" have half the death rate of men who are unfit/"thin."

(S. Blair, Cooper Institute 2001)



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MYTH #2
WEIGHT AND HEALTH CONDITIONS

When you use BMI to determine health:

- **-You mislabel 50% of "overweight" adults**
- **-You mislabel 30% of "obese" adults**
- **-You mislabel 25% of "normal" weight adults**
- **-54 million adults incorrectly labeled as unhealthy**

R. Wildman, 2008, Archives of Internal Medicine and J. Tomiyama, 2016 Journal of Obesity

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CORRELATION VS. CAUSATION

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The Obesity Paradox

- Blood Pressure
- Cardiovascular Disease
- Stroke
- Diabetes

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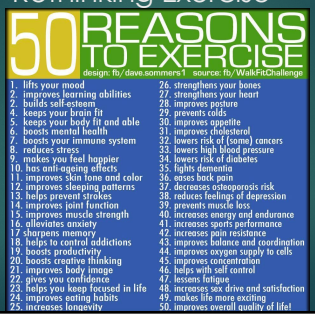
Rethinking Exercise



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23 ½ HOURS

85

HEALTH IS MUCH BROADER THAN THE NUMBER ON THE SCALE

- Practice and encourage positive, sustainable behaviors. Every body gets to pursue health to the degree they choose, given what's accessible to them.

"…health is not an obligations, barometer of worthiness, entirely under our control or guaranteed under any circumstances." —Ragen Chastain, Dances With Fat

86

MYTH #3 THE PURSUIT OF WEIGHT LOSS

- **Increases health problems**
- **Puts people at greater risk for eating disorders**
- **Ignores the social determinants of health**
- **Contributes to weight stigma**

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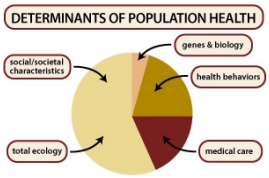
SOCIAL DETERMINANTS OF HEALTH



Tarlov, A.R. (1999) Public Policy Frameworks for Improving Population Health

"What if your zip code has more of an affect on your health than your weight?"
(Powell, T. et. al. 2015, Journal of Preventive Medicine)

88

WEIGHT BIAS

- **"In a study of 400 doctors, one of every three listed obesity as a condition to which they responded negatively…They associated [it] with noncompliance, hostility, dishonesty, and poor hygiene."**
- **"Psychologists ascribe more pathology, more negative and severe symptoms and worse prognosis to obese patients compared to thinner patients presenting *identical psycholgoical profiles.*"**
  (Weight Bias: A Social Justice Issue Policy Brief (2012) Yale Rudd Center)
- **"I believe the #1 medical complication of BED is sub-standard general medical and surgical care, arising from weight stigma."**
- Jennifer L. Gaudiani, MD, CEDS

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EXPOSURE TO WEIGHT STIGMA/ FAT SHAMING

- **-Increased risk for cardiovascular disease (Pearl, R. et. al., Association Between Weight Bias Internalization and Metabolic Syndrome Among Treatment-Seeking Individuals With Obesity.)**
- **-Increased risk for metabolic disease (Pearl, R. et. al., Association Between Weight Bias Internalization and Metabolic Syndrome Among Treatment-Seeking Individuals With Obesity.)**
- **-Increased risk for cervical cancer (A. Saguay, *What's Wrong With Fat?*)**
- **-Increased inflammation and cortisol levels (A. J. Tomiyama, How and Why Weight Stigma Drives The Obesity 'Epidemic' and Harms Health.)**
- **-60% increased risk of dying independent of BMI (A. J. Tomiyama, How and Why Weight Stigma Drives The Obesity 'Epidemic' and Harms Health.)**
- **-2.5 times as likely to experience anxiety or mood disorders (A. J. Tomiyama, How and Why Weight Stigma Drives The Obesity 'Epidemic' and Harms Health.)**

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LIMITATIONS OF RESEARCH/ POTENTIAL RISKS

CAUSATION VS. CORRELATION

- How can we separate the effects of fat tissue from exposure to weight stigma?
- Why do we assume that a higher weight person who loses weight will have the same health outcomes as someone who has always been at a lower, steady weight?
- How can we research this question when we don't have people who are able to sustain weight loss long enough to become part of a study?

91

INTERSECTING IDENTITIES

Body shame often intersects with racism, homophobia, gender struggles, and ableism, reinforcing the value of one body over another.

How can we challenge these systems?

92

THIN (AND OTHER) PRIVILEGES

What are some examples of unearned advantages that come from being "thin" in our culture?

What other privileges do we have? How does that impact what we do as clinicians?

93

BODY POSITIVITY REVISITED
LET'S TALK ABOUT WHAT IT ISN'T!

- A requirement to feel beautiful and love your body all the time. (Instead, unhook your body image from your worth as a human being.)
- Permission to not care about your health or self-care (Instead, understand that you're more likely to take care of what you accept and love, while at the same time, you have the right to choose how you do – or don't – take care of your body.
- A marketing campaign with the message that you need to change your body so that you can feel good about your body (Instead, start from a place of acceptance.)
- A message for people in the mainstream e.g. white, cisgender, slightly fatter (Instead, include groups that have been marginalized such as people in much larger bodies, people of color, people who are disabled, and gender queer people.)

body neutrality. body trust. body respect.
body confidence. body liberation.

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BODY IMAGE, SHAME & WEIGHT STIGMA

"Size-based oppression is not in our heads and it's not something that we can just overcome with body love, confidence, and a can-do attitude. We need social and structural changes to put an end to size-based oppression…fat phobia isn't our fault, but it becomes our problem."

(Ragen Chastain, Dances With Fat, 3/6/18)

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LISTEN TO THE VOICES OF THOSE WITH LIVED EXPERIENCE

"There's a reason why I prefer 'fat positivity' to 'body positivity.' Fat positivity isn't a subcategory of body positivity; it is a prerequisite. Because without a full reckoning of what it means to honor all bodies unconditionally, 'body positivity' becomes just another thing to fail at, just another impossible gendered expectation. We're supposed to be hot in all the old ways while appearing liberated in the new ones. We're expected to devote ourselves to weight loss as much as our mothers and grandmothers did, while at the same time orchestrating an elaborate cover-up: this modern weight loss is always a coincidence, a byproduct of our 'wellness practice,' an incidental surprise."

(Lindy West, Self 2018, guest edited by Jeanna Oluo)

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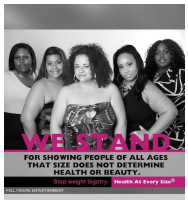
WHY HAES MATTERS

- **Health**
- **Body Image/Appearance**
- **Weight Stigma**
- **Social Justice**



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HAES PRINCIPLES

- **4) Eating for Well-Being:** Promote flexible, individualized eating based on hunger, satiety, nutritional needs, and pleasure, rather than any externally regulated eating plan focused on weight control.
- **5) Life-Enhancing Movement:** Support physical activities that allow people of all sizes, abilities and interests to engage in enjoyable movement, to the degree that they choose.

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HAES PRINCIPLES (continued)

- **1)Weight inclusivity:** Accept and respect the inherent diversity of body shapes and sizes and reject the idealizing or pathologizing of specific weights.
- **2) Health Enhancement:** Support health policies that improve and equalize access to information and services, and personal practices that improve well-being, including attention to individual, physical, economic, social, spiritual, emotional and other needs.
- **3) Respectful care:** Acknowledge our biases, and work to end weight discrimination, weight stigma, and weight bias. Provide information and services from an understanding that socio-economic status, race, gender, sexual orientation, age, and other identities impact weight stigma, and support environments that address these inequities.

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3 COMMON MYTHS ABOUT THE HAES FRAMEWORK

Health At Every Size means that all higher weight people can be healthy.

Health At Every Size is against weight loss.

Health At Every Size is only relevant to people at higher weights.

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BECOME A HAES-INFORMED THERAPIST

Recognize that:

- **Behaviors considered eating disordered in thinner people are often prescribed to higher weight people.**
- **All types of eating disorders occur in people of all shapes and sizes. At the same time, people of all shapes and sizes do not necessarily have an eating disorder.**
- **Successful recovery from Binge Eating Disorder is not dependent on weight loss.**

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HAES MATTERS

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OUR NEXT GENERATION

- The body type portrayed in advertising as the ideal is possessed naturally by only 5% of American females
- 42% of 1st – 3rd grade girls want to be thinner
- 81% of 10 year olds are afraid of being fat
- 78% of 17 year old girls are unhappy with their bodies

(from: www.anad.org)

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BODY DISSASTIFACTION LEADS TO DIETING

- Over 50% of teenage girls and 33% of teenage boys use restrictive measures to lose weight at any given time
- 46% of 9 – 11 year olds are sometimes, or very often, on diets, and
- 82% of their families are sometimes, or very often, on diets
- 91% of women surveyed on a college campus had attempted to control their weight through dieting. 22% dieted "often" or "always.

(From: www.eatingdisorderhope.com)

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CHANGING THE CONVERSATION ABOUT DIETING, FOOD AND WEIGHT

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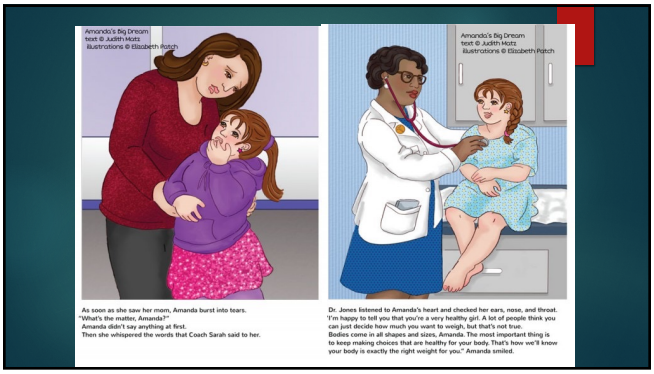

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CHANGING THE CULTURE ONE ACTION AT A TIME

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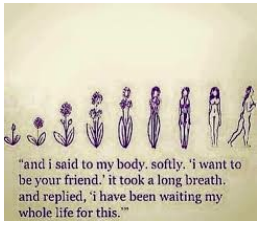
WHAT IS RECOVERY?



Nayyirah Waheed

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BEYOND THE CLINICAL

YOU are the pebble that creates the ripples…

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BY JUDITH MATZ

Health Comes in All Sizes

THE HAES APPROACH TO COUNTERING WEIGHT STIGMA

Q: I've seen increasing references to the Health at Every Size (HAES) approach to treating eating and body-image issues. That's not my clinical specialty, but is this framework relevant to my work?

A: When I look back on my 35 years of practice, I recognize important, overarching paradigm shifts that have changed the way we work with clients. Becoming trauma informed, even if we don't specialize in trauma, and no longer pathologizing people who identify as LGBTQ, are just two examples that come to mind.

Similarly, a paradigm shift around weight and wellness is occurring in our field with the Health at Every Size (HAES) framework. Societal norms regarding weight, health, and eating affect every client we work with, regardless of body size. We're inundated every day with messages from family, friends, colleagues, media, and even doctors and mental health professionals that prioritize weight over well-being; promise health, happiness, and success to those who can conform to a certain ideal; pressure people to pursue thinness and fear fat at all costs; presume that people have control over what they weigh; pose as health promoting, even as they harm; and promote fat shaming and weight stigma. We call these negative messages the six P's of diet culture.

While therapists often support the pursuit of weight loss as an act of self-care, overwhelming evidence indicates that dieting almost always leads to negative physical and emotional consequences. By becoming HAES informed, you can support people of all sizes when it comes to respecting and taking care of their bodies without inadvertently causing harm.

A Movement Is Born

In the early 2000s, many of us who reached the same conclusions about weight and well-being came together to figure out how to combat these societal pressures. We knew that the vast majority of people who diet gain the weight back, and that the human body adapts to these periods of deprivation by raising its set point and becoming heavier over time. We witnessed the universal feelings of shame induced by diet failure and the toll it took on people from all walks of life.

We also observed, or experienced ourselves, that while many people practiced positive self-care related to food and other areas of their lives, they didn't necessarily lose weight. Given the lack of evidence to show that weight loss can be sustained over a two- to five-year period, and research showing that weight cycling actually leads to poorer health outcomes, was it reasonable, fair, or even ethical to demand that people diet to fit society's standards?

At its core, HAES is a weight-inclusive philosophy, which seeks respectful treatment for people of all sizes, offering a path for wellness beyond weight. It focuses on teaching people to eat in accordance with hunger and satiety cues that are in line with the body's natural needs, rather than the rigid prescriptions of a diet. It also encourages physical activity for pleasure and health benefits, rather than the pursuit of weight loss. But beyond individual behaviors, it helps people understand broader social-justice issues related to body size, including weight bias, stigma, bullying, and discrimination.

Challenging Myths and Implicit Bias

The biggest concern people express about the HAES movement is that by countering diet culture and weight stigma, we're somehow disregarding people's health. But that's far from true. According to research from the Centers for Disease Control and Prevention, people in the "overweight" category of the Body Mass Index (BMI) have the longest lifespans, and people in the "normal" category have the same mortality rate as those in the lower end of the "obese" category. In fact, people who fall into the "obese" category of BMI and are fit have half the mortality rate of people who are thin and sedentary. Using BMI to assess health status is actually wrong about 50 percent of the time.

It's a myth to interpret HAES as suggesting all higher-weight people can be healthy. Health is a continuum, and people at both higher and lower weights can be healthy and unhealthy. Studies show that behaviors such as maintaining fitness can improve health regardless of whether weight is lost. HAES encourages people to take care of their bodies: if weight changes occur, that's a side effect, but not the goal. The HAES philosophy contends that people of all sizes deserve to pursue—and have equal access to—resources that support their bodies in achieving optimal health as they define it.

Most clinicians would support this

philosophy in theory, but when I ask therapists in my trainings to assess their attitudes toward *thin* and *fat*, I often find them unaware of the weight biases they carry and how these beliefs affect all types of treatment. At a recent workshop, for instance, Jonathan realized that even though he'd never express his judgments about someone's fatness out loud, he still thinks them—and he wondered if his clients could pick up on that. Eva shared that while she doesn't judge her clients, she's very hard on herself. As she explored countertransference issues, she acknowledged feeling jealous of her thinner clients.

Carla revealed that she works in an eating disorder center where staff frequently describe food as "good" or "bad." She knows this diet mentality is counterproductive to the goals of eating disorder treatment, but as a higher-weight therapist herself, she feels uncomfortable challenging her colleagues, and even eating around them. Naming these beliefs and attitudes, along with the understanding that this is an ongoing learning process, is part of the shift toward becoming a HAES-informed professional.

HAES-Informed Therapy in Action

Anita came to me after terminating with her previous therapist, whom she'd been seeing for help with her anxiety. Over the course of their work, she'd revealed her struggle with overeating and her goal of losing weight. In response, he'd suggested that she cut out high-fat foods, such as butter, and stop bringing them into her home. *Fine*, Anita thought, *I'll do that.* But over time, her bingeing increased, her therapist grew disappointed, and she contacted me to figure out what to do next. This is a typical scenario, where therapists, with the best of intentions, reinforce unhelpful beliefs about eating and weight that are woven into diet culture and almost always backfire.

Instead, as a HAES-informed therapist, I helped Anita develop the ability to eat when hungry, tune into what she was hungry for, given a wide variety of foods to choose from, and stop when satisfied. Through mindfulness techniques and building her support network, she learned to manage her anxiety better without reaching for food. She started swimming regularly and wearing clothes that made her feel attractive and comfortable. As she practiced and sustained these positive, healthful behaviors, her weight stabilized. And as we talked about the ways she'd internalized weight stigma, she became increasingly more accepting of her larger body.

The trouble for Anita was that outside of our sessions, she was bombarded with cultural messages indicating her size was a problem. At family dinners, relatives talked about their latest fad diets and urged her to try them. When Anita went out with friends, they bemoaned their own body sizes, even though they were smaller than her. Even Anita's doctor confused her by suggesting it would be a good idea to lose weight, despite her excellent cholesterol, blood-pressure, and blood-sugar readings. Like many clients, she found herself in a bind: to shed pounds, she'd have to under-eat or over-exercise—behaviors she knew were considered unhealthy in eating disordered clients.

Together, Anita and I brainstormed strategies that would help her manage the weight stigma she was encountering. When family and friends started talking diets, she redirected the conversation to topics like travel and work. She also found the courage to give her doctor an article about the HAES approach. Whether it's in our clinical work or personal lives, a HAES lens means that we no longer send messages that weight loss trumps well-being.

In this sense, it's critical to support clients in advocating for themselves so they can meet their needs and live fully in the world. Heidi was a higher-weight woman in recovery from binge eating disorder, whose body size exacerbated her knee problems. From a HAES perspective, I helped her role-play how she'd approach the new orthopedic doctor she'd be visiting the following week.

"You can see I'm fat," she began, "I know my weight may affect my knees, and I know that you see people with knee problems who aren't fat. My weight may not change, so I want to be given the same treatment you'd give them." While the doctor did tell her that some weight loss might help, he didn't demand it, shame her, or withhold treatment. Instead, he offered alternative interventions that helped her walk with much less pain. She was thrilled to be able to follow through with plans to visit her relatives and hike some beautiful nearby trails. She felt so empowered that she signed up for a yoga teacher training and now plans to offer plus-size yoga to give higher-weight people a safe place to practice.

The Bigger Picture

With greater understanding in recent years about different types of privileged statuses and systemic structures that unfairly affect people in marginalized groups, the HAES framework continues to evolve in its efforts to heighten awareness of the role that bias and oppression play in a person's health. Data shows that a person's zip code, for example, is more predictive of their health than BMI.

It may seem counterintuitive, but adults with greater body satisfaction across the weight spectrum report more positive health behaviors and have better health status regardless of BMI. Because the terms *overweight* (over what weight?) and *obesity* (which implies sickness) contribute to weight stigma, HAES-informed people use more neutral terms, such as *higher weight* or *large* to refer to body size. In fact, the word *fat* has been reclaimed by many in the size-acceptance movement as a neutral or positive descriptor, similar to how *queer* is now used as a positive identity within the LGBTQ community.

Paradigm shifts are difficult. They require us to look deeply at our own attitudes, biases, and values—and how they match up with the research and our clients' lived experiences. Of course, we all know someone who lost weight and kept it off, but we need to recognize that this is the exception, rather than the norm. We all have clients who feel it's imperative to lose weight in order to live a good life, and many of us struggle with weight concerns ourselves. There's nothing easy or comfortable about this.

Hopefully, we can all agree that respecting people of all body sizes and ending fat shaming is good for everyone. If clients share that they come from a HAES perspective, we can support them without thinking they're giving up and not taking care of themselves, and without judging character based on body size. Given the massive failure of the traditional weight-focused model, becoming HAES-informed offers a way to avoid being complicit in our clients' experiences of diet failure, shame, and weight stigma.

Imagine a world where people of all body shapes and sizes felt respected and free to take care of their physical and emotional needs without a weight requirement. As Maya Angleou wrote, "Do the best you can until you know better. Then when you know better, do better."

Judith Matz, LCSW, is coauthor of Beyond a Shadow of a Diet: The Comprehensive Guide to Treating Binge Eating Disorder, Compulsive Eating, and Emotional Overeating *and* The Diet Survivor's Handbook: 60 Lessons in Eating, Acceptance and Self-Care. *She's a speaker and trainer with a private practice in Skokie, IL. Contact: judmatz@gmail.com.*

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BY JUDITH MATZ

Beyond Lip Service

CONFRONTING OUR PREJUDICES AGAINST HIGHER-WEIGHT CLIENTS

Q: I'm comfortable working with clients on all types of issues, but I notice that I feel a sense of disapproval toward clients I consider fat. How can I change my attitude?

A: When I started specializing in eating and weight issues, I made many of the negative assumptions that are common in our culture about people who are considered fat. I assumed that they were overweight simply because they were overeating, and that if they only normalized their relationship with food, they'd lose weight and be healthy and happy. Despite my best efforts to accept them for who they were, some part of me still made judgments about their body size.

Over the past couple of decades, I've spent a lot of time examining my own attitudes about body size, weight, and health. I've delved into research that shows overwhelmingly that diets and weight-management programs produce only short-term weight loss. To date, not a single program has data to show long-term success, considered to be two to five years. Although you may know someone who has sustained a substantial weight loss, the chances for that outcome are about 5 in 100.

In shifting how you think about—and ultimately help—your clients, it's useful to consider the idea that weight is a characteristic, not a behavior. It's not simply a matter of calories in and calories out, and our weight-regulation system is largely outside of conscious control. All sorts of variables influence weight, including genetics, frequency of yo-yo dieting, medications, and the environment. By focusing on sustainable behaviors, such as exercise, eating a wide variety of food, getting a good night's sleep, and practicing mindfulness or meditation, your clients are in the strongest position to reach their goals for health and well-being, *regardless* of whether they lose weight in the process. Likewise, for higher-weight clients who struggle with binge or emotional overeating, resolving these issues can, but won't necessarily, result in some weight loss as a side effect. This paradigm, known as the Health at Every Size (HAES) approach, is gaining greater recognition as an evidence-based framework that supports the well-being of people of all shapes and sizes.

I've come to believe that the way we as therapists feel about our clients' body size is not only a clinical concern, but a social justice issue. It's not easy to challenge internal attitudes that are reinforced every day in the general culture, but if you're willing to go against the cultural current, here are some things you can do to help you assess—and transform—your internalized views about weight and dieting.

Practice empathy. To begin with, it's important to pay special attention to the struggles of your higher-weight clients as they share their stories about how they've viewed their bodies and how others have responded to them. Nina, for example, is one of my larger-sized clients who tries to take care of herself by swimming at her local YMCA a couple of times a week. She loves the way she feels after exercise, but she explained to me that she frequently overhears negative comments from other women about her size when she's in the locker room. On days when she feels stronger, she ignores the comments and gets herself into the pool, but on days when she feels the shame that's been with her since childhood, she can barely get through the experience.

As you listen to your clients' experiences of how they've tried to deal with their weight and the stigma they suffer, you may notice your view changing from disapproval to compassion. Or you may find yourself thinking, *If she just lost weight, she wouldn't have to experience these judgments.* But you should consider how that attitude blames the victim, which does little to help the client and perpetuates a culture of prejudice.

Examine internalized stigmas. Weightism, also known as weight stigma, refers to judging another person based on his or her shape or size. As with other forms of discrimination, weightism fuels behaviors such as bullying and hate speech, and it can limit an affected person's access to education, employment, and healthcare. There's also an abundance of evidence that the chronic stress that comes from being part of a stigmatized group can increase rates of long-term health problems.

When I conduct workshops on weight stigma for therapists, I ask participants to call out their associations to the words *thin* and *fat.* Typically, they associate *thin* with

the words *successful, happy, confident, sexy,* and *healthy;* and they associate *fat* with the words *unhealthy, lazy, out of control, miserable,* and *stupid.* You can take a test online that measures implicit attitudes toward weight by going to Harvard's Project Implicit at implicit.harvard.edu/implicit.

These associations are so common that many therapists don't realize that they're attaching them to their higher-weight clients. Also, it's important to keep in mind that an oppressed group often internalizes negative associations. Your client may believe that because of her size, she's unlovable or worthless, and your own feelings toward her size have the power to reinforce her beliefs or help her move from shame toward a place of acceptance, self-compassion, and self-care. The Association for Size Diversity and Health, a professional organization composed of members committed to the HAES principles, can offer you helpful information to support your clients.

Expose and challenge yourself. As with other groups that reclaim a term that's been used against them, there's been a movement to take back the word *fat* as merely a description of size, rather than a derogatory word. When my clients want to learn more about the size-acceptance movement, I suggest they read the blog "Dances with Fat" by Ragen Chastain, a large woman who's an award-winning ballroom dancer. She writes, "My greatest accomplishment has been learning to love myself and my body, and to be truly happy living completely outside the cultural beauty norm. As a plus-sized professional athlete, I practice Health at Every Size and as a human being I'm an unwavering advocate for Size Acceptance—the civil rights truth that every body deserves respect and that the rights to life, liberty, and the pursuit of happiness are inalienable, not contingent on size, health, or dis/ability." Her blog entries are one of many resources that give insight into the experiences of a fat person at psychological, social, cultural, and political levels.

There are also educational resources that dispel myths about people at higher weights. The National Association to Advance Fat Acceptance, for instance, is a civil-rights organization dedicated to ending size discrimination and building a society where people of every size are treated with dignity and equality in all aspects of life. Their *Guidelines for Therapists Who Treat Fat Patients* examine common assumptions made by mental health professionals and offer stereotype-management skills.

Seek affirmations. Confirmation bias is the tendency to pay attention to information that confirms our beliefs and ignore information that doesn't, especially when it comes to emotionally charged or deeply entrenched issues. The fear of fat runs so deep in our culture that it may be hard to consider letting go of these beliefs. At a personal level, I encourage you to become aware of the lens you use to evaluate people based on size, and then to challenge your ingrained stereotypes. Think about higher-weight people you know—friends, family members, colleagues—who affirm that fat people can be smart, healthy, in good relationships, and attractive. The converse is to think of thinner people you know who have health issues, struggle in relationships, and don't look particularly attractive. The point, of course, isn't to start judging these friends and colleagues, but to unhook your assumptions about people based on their weight.

Practice self-compassion. If you want to shift your attitudes toward higher-weight clients, it may take time to make these changes at a deep level in your psyche. At the same time, as members of a profession we have an obligation to move forward.

One participant approached me the day after a workshop and said how upset she was to recognize that she's been assuming these automatic negative attitudes based on stereotypes. My response to her was that it's wonderful that she's now aware of these attitudes so that she can challenge and reevaluate her beliefs.

In my own journey, I've spent countless hours listening to the challenges and victories of people of higher weights. Witnessing the transformation that occurs when people learn to let go of the shame and treat themselves with acceptance has transformed me.

Moving beyond cultural stereotypes and fully embracing one's humanity is difficult, but it can be done, as one of my former clients recently expressed at a conference.

"At 37, the worldview that I accepted told me that I wasn't really worthy of much with a larger body," she said, "even though I was a strong and courageous mother, loved by a wonderful and caring husband, and extremely successful as an elementary schoolteacher and teachers' mentor. In my inner world, the only way to be worthwhile was to be thin. Twenty years later, I've become me. The judgments are gone; the self-esteem issues are gone; righteousness when I stayed on a diet is gone. I don't physically look like I thought I would, or even how I may eventually look someday—who knows?—but I'm happy, peaceful, and extremely thankful."

Judith Matz, LCSW, is the coauthor of Beyond a Shadow of a Diet: The Comprehensive Guide to Treating Binge Eating Disorder, Compulsive Eating and Emotional Overeating *(April 2014) and* The Diet Survivor's Handbook: 60 Lessons in Eating, Acceptance and Self-Care. *She's the director of the Chicago Center for Overcoming Overeating, Inc. and has a private practice in Skokie, Illinois. Contact: judmatz@gmail.com.*

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