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Welcome to the World of Weight Stigma

In America, there is a strongly negative attitude towards obesity. Public health incessantly communicates the health consequences of obesity. Many Americans resort to drastic fad diets and brutal exercise regimes to avoid being fat. Obese people are ridiculed for their weight. With this pervasive negative attitude toward obesity (fatphobia), one would think that obesity would be effectively curbed. However, the USA has one of the highest obesity rates in the world. Ironic, right? This high obesity rate is just one evidence of fatphobia's alarming consequences. Instead of solely communicating obesity's health concerns, I believe public health should also address fatphobia since this issue brings about perpetuated obesity, eating disorders, and social discrimination against obese people.

How, then, should public health fight fat phobia? One approach that has been championed as a solution is the Health at Every Size (HAES) approach. The Association for Size Diversity and Health, which has trademarked HAES, states the five principles of this approach on their website: "weight inclusivity, health enhancement, eating for well-being, respectful care, and life-enhancing movement" ("The Health at Every Size® (HAES®) Approach"). Simply put, the HAES approach rejects the traditional weight-focused approach; it does not see the Basal Metabolic Index (BMI), the most common measure of obesity, as an accurate definition of health (Penney and Kirk e39). Instead, HAES emphasizes that healthy behaviors are the true indicator of health. This approach stands by three main principles: intuitive eating, enjoyable physical

exercise, and acceptance of diverse body types. In addition, the HAES approach advocates for quality healthcare for all and an environment in which everyone has the resources to live a healthy lifestyle ("The Health at Every Size® (HAES®) Approach").

Within the medical community, the HAES approach has been incessantly debated. On one hand, several medical professionals reject HAES and adhere to the traditional weight-focused approach. Amanda Sainsbury, an Australian medical researcher specializing in metabolism and eating disorders, argues that HAES cannot effectively address obesity's dire health outcomes. She stresses the dangers of having an obese BMI (BMI > 30), like an increased risk of stroke, type 2 diabetes, and cardiac disease. Sainsbury also introduces the hypothesized effects of unaddressed obesity: altered brain chemistry and genetics. If an obese individual does not lose weight as soon as possible, their brain could make their body hold onto fat, causing weight loss to be extremely difficult and potentially unattainable (Sainsbury). Also, an obese individual's genetics could alter to make obesity a genetic trait. If this trait is passed down to their offspring, the offspring's health could be negatively impacted (Sainsbury). Even though these concerns are still just hypotheses, Sainsbury still rejects HAES since she believes that obesity's health concerns are too serious to ignore.

On the other hand, some medical professionals consider the strengths and weaknesses of the HAES approach. Tarra Penney and Sara Kirk, researchers at Applied Research Collaborations for Health at Dalhousie University, acknowledge that HAES brings about several benefits that the weight-focused approach does not. They share studies that show that the HAES approach can improve hunger levels, mental health, and self-esteem (e40). Besides, the researchers state that HAES can help with stable weight maintenance, which is rare for dieters who struggle with drastic weight fluctuations (e40). Finally, Penney and Kirk share that by

promoting body acceptance at all levels of society—family, community, media, healthcare, school, and work—the HAES approach eliminates the shame associated with being obese, therefore curbing pervasive weight stigma. Although HAES has many promising strengths, the authors also point out HAES's weaknesses. Penney and Kirk point out that many studies on intuitive eating have been conducted on limited populations—fad dieters and people with eating disorders. To be accepted as a public health approach, HAES must enhance the health of the entire general population (underweight, normal weight, overweight, and obese), not just fad dieters and people with eating disorders. Furthermore, the researchers mention that the HAES approach may be inappropriate for morbidly obese people because they could reap benefits from weight loss, like increased mobility.

Finally, several medical professionals advocate for the HAES approach. Dr. Wayne Miller, professor of exercise science and nutrition at George Washington University, discusses fallacies in the traditional weight-focused approach and calls his colleagues to implement HAES into their practice. The author asserts that fatphobia prevails in the field of medicine, creating unreasonable health benchmarks. For example, Miller shares that the ideal BMI range of 18.5-19 is nonsensical because it only permits a weight fluctuation of 3 lbs. The widespread fatphobia in medicine influences society, creating an environment that pushes for, in Miller's words, "weight loss at any cost" (S90). To support the notion that weight is not an indicator of health, Miller shares a study that found that fitness levels, not obesity levels, are correlated with higher mortality. This study demonstrated that normal weight, overweight, and obese individuals who engaged in healthful exercise and eating were posed with a lower risk for mortality compared to normal weight, overweight, and obese individuals who did not exercise and eat healthy. With this evidence, Miller emphasizes that behaviors, not body weight or size, should define health

because focusing on behaviors encourages long-term, healthy lifestyle changes. For this reason, Miller calls for his colleagues to focus on their clients' behaviors rather than their weight.

With so many conflicting viewpoints surrounding the HAES approach, I first felt unsure of which stance I should take. Although I do not entirely accept the HAES approach, now I certainly favor it over the traditional weight-focused approach because it addresses fatphobia's consequences. One ironic outcome of fatphobia is perpetuated obesity. Many would think that the shame associated with obesity would motivate obese people to lose weight. However, the exact opposite is true. Puhl and Heuer, researchers at the Rudd Center for Food Policy and Obesity at Yale University, share that obese women have admitted that they binge eat to cope with weight stigma (1022). Other studies show that many obese adults respond to weight stigma by avoiding physical activity (Puhl and Heuer 1022). Researchers Haines and Neumark-Sztainer found that obese adolescents respond to weight stigma similarly—after being teased for their weight, they are prone to binge eating and become hesitant to engage in exercise (775).

Since the HAES approach is weight-neutral, it does not specifically endorse weight loss. However, weight reduction has occasionally been a result of HAES-based treatments (Penney and Kirk e40). Contrary to the belief that the HAES approach encourages obesity, this evidence shows that HAES can occasionally result in weight loss, which may appeal to medical professionals who adamantly believe in the weight-focused approach. It is also important to note that HAES-based treatments have helped subjects experience decreased hunger and stable weight maintenance (Penney and Kirk e39), whereas weight-loss dieting causes people to experience increased hunger and weight regain (Bombak e60). Furthermore, HAES-based treatments have fostered long-term, positive behavior changes, like consistent healthy eating. On the other hand, weight-focused approaches have only created temporary behavior changes (Penney and Kirk

e40). With this evidence, I conclude that the HAES approach is a considerable way to address rising obesity rates.

In addition to perpetuated obesity, the HAES approach targets eating disorders, another dire outcome of fatphobia. This issue significantly matters to me since my close friend struggles with severe food restricting and binging. His eating disorder behaviors were first sparked by his poor body image. After comparing himself with the unrealistic body standards for men, he was compelled to go on a diet. In the process of dieting, he became obsessed with calorie counting, food measuring, calorie restricting, fasting, and following strict meal timings. Not only did he engage in food restriction. When his hunger became too much to bear, he resorted to the other extreme, binging. Feeling overwhelmed with guilt, he punished himself with starvation only to eventually binge again. It is painful for me to watch my friend continue to live in this miserable binge-restrict cycle. What is even more concerning is that he is not the only young adult who has developed an eating disorder because of fatphobia. Fatphobia's consequences of body dissatisfaction and dieting are common triggers for eating disorders in many adolescents (Haines and Neumark-Sztainer 772, 775-776).

To target harmful eating disorder behaviors, the HAES approach utilizes the principles of intuitive eating and body acceptance. According to Lauren Muhlheim, an expert clinical psychologist in eating disorders, intuitive eating is a unique approach which essentially encourages one to trust and honor their body in their relationship with food. The principles of intuitive eating include being mindful of hunger and fullness cues, allowing oneself to respond to food cravings, not demonizing any foods, and abandoning restrictive behaviors like calorie tracking (Muhlheim). Muhlheim shares that research finds that "Intuitive eating is associated with lower use of unhealthy weight control behaviors and disordered eating (fasting, skipping

meals, taking diet pills, vomiting, and binge eating).” Basically, she provides evidence that by trusting and honoring their bodies, people with eating disorders have been able to overcome their turbulent relationship with food. Furthermore, the HAES principle of body acceptance also is vital in eating disorder recovery. By promoting body acceptance throughout all levels of society—family, community, media, healthcare, school, and work—the HAES approach fosters an ideal environment which encourages people in eating disorder recovery to accept and appreciate their bodies. With improved body image, these people are encouraged to cease their self-destructive dieting which forces their bodies to fit society’s glorified thin body standard (Penney and Kirk e39). Body acceptance throughout society could even aid with eating disorder prevention because it could curb widespread body dissatisfaction which often triggers eating disorders (Haines and Neumark-Sztainer 775-776).

Finally, HAES addresses perhaps the most troubling consequence of fatphobia: social discrimination against obese people. Obese people are incessantly and unfairly judged everywhere. They are ridiculed for their weight at school, work, and home (Puhl and Heuer 1023). There are especially concerning instances of fatphobia within healthcare. Obese people report that their doctors do not take them seriously. Instead of carefully evaluating their concerns, their doctors quickly deem their obesity as the cause of all their health problems and prescribe weight loss as a solution (Puhl and Heuer 1023). Research done on the personal fatphobic bias of some doctors is even more troubling. Puhl and Heuer share, “Both self-report and experimental research demonstrate negative stereotypes and attitudes toward obese patients by a range of health care providers and fitness professionals, including views that obese patients are lazy, lacking in self-discipline, dishonest, unintelligent, annoying, and noncompliant with treatment” (1023). In other words, Puhl and Heuer state that many health professionals hold

pessimistic, discriminatory attitudes towards obese patients. These biased attitudes are exceedingly concerning, for they prevent obese patients from receiving the quality care they deserve.

With its principles of weight inclusivity and respectful care, the HAES approach effectively targets the pervasive weight stigma throughout American society. First off, HAES embraces all body types—underweight, normal weight, overweight, and obese—not shaming or endorsing any specific body type. The weight-neutral mindset of the HAES approach removes the shame associated with being obese, therefore preventing weight stigma (Penney and Kirk e39). Finally, with its respectful care principle, the HAES approach advocates for the proper care and fair treatment of all patients, especially obese patients. This principle is especially geared toward health professionals whose fatphobic mindsets inhibit them from providing the best care to their obese patients. To address this issue, Puhl and Heuer emphasize that health professionals should undergo training which dismantles their fatphobic attitudes. This training will ensure that they provide quality service to all patients and end pervasive weight stigma (1025).

Although considerable research supports HAES, many medical professionals still strongly oppose this health approach. For example, Sainsbury strongly rejects HAES because she believes obesity's health concerns are too urgent to be ignored. I agree that obesity does pose many physiological health risks. However, I believe fatphobia is also very concerning because it threatens not just one, but three aspects of health: physiological, psychological, and social health. As I mentioned earlier, fatphobia leads to rampant eating disorders, low-quality health care for overweight people, and even higher rates of obesity. I am sure Sainsbury can agree that these health concerns cannot be ignored, too.

The HAES approach may still be opposed by health professionals, like Penney and Kirk, who argue that this approach is unideal in America's obesogenic (obesity-causing) environment. I agree that it is easy to become obese in America. Non-nutritious foods are certainly more affordable and accessible than nutritious foods (Bombak e61). Furthermore, many Americans live a sedentary lifestyle—there are limited opportunities for physical exercise with widespread dependence on transportation and a decrease in physically demanding jobs (Bombak e61). However, I believe Penney and Kirk overlook the fact that the HAES approach *does* consider these issues. On their website, ASDAH says, "…the HAES model 'is an approach to both policy and individual decision-making, addressing broad forces, such as safe and affordable access, that affect health' and with the assertion that it is an approach that 'grounds itself in a social justice framework.'" ("The Health at Every Size® (HAES®) Approach"). In other words, ASDAH claims that one of HAES's ultimate goals is to achieve social justice for underprivileged Americans by eliminating all barriers which prevent them from living healthy lifestyles. These barriers certainly include inaccessible nutritious foods and insufficient exercise opportunities, the major contributors to America's obesogenic environment.

In summary, fatphobia sparks the grave consequences of eating disorders, perpetuated obesity, and unfair treatment of overweight people. This issue certainly matters to doctors, overweight people, and people who struggle with eating disorders because they are first hand witnesses to its negative effects. However, we all should desire to urgently address fatphobia because what is ultimately at stake is the psychological, physiological, and social well-being of many Americans. If we target fatphobia now, our future generations could optimistically look forward to an environment that fully supports all aspects of their well-being—truly, a hopeful future worth fighting for.

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