You may have noticed,
I am not Kim Chernin.

And this is not a keynote speech on the HCG diet.
This is a speech about how the EDRS did a courageous thing and said no to a weight loss presentation.

Why is this a courageous and important act?
Conventional thinking about the pursuit of weight loss

Things people do to make them healthier in the long run

Things people do to lose weight
What you learn as an eating disorders clinician

- Things people do to make them healthier in the long run
- Things people do to lose weight
People who try to lose weight

Regain 88-95%

Maintain 5-12%

No further disordered eating, but probably fatter

Disordered eating or BED, BN, EDNOS

No further disordered eating

Disordered eating

AN, BN EDNOS BED?

The only good outcome – at best, less than 1 person in 10
Evaluated all existing studies following dieters for at least 2 years.

“These studies show that one-third to two-thirds of dieters regain more weight than they lost on their diets, and these studies likely underestimate the extent to which dieting is counterproductive because of several methodological problems, all of which bias the studies toward showing successful weight loss maintenance.”

“In addition, the studies do not provide consistent evidence that dieting results in significant health improvements, regardless of weight change.”

“In sum, there is little support for the notion that diets lead to lasting weight loss or health benefits.”

It is 6 times more likely for a person with anorexia to have sustained their restored weight 2 years out, than for the average person to maintain their weight loss 2 years out.
$60\text{bil} \text{ weight cycling industry}

or, more accurately,

WeightCyclers
Weight loss maintainer or eating disorder patient?

- I avoid anything with sugar or white flour.
- I carry a scale when I travel.
- [M]y body would put on weight almost instantaneously if I ever let up.
- I weigh myself every morning and record the result in a weight diary.
- I drink 5 20-oz bottles of water a day.
- I devote my life to not gaining weight.
- I exercise from 100 to 120 minutes a day, six or seven days a week.
- I write down everything I eat. At night I transfer all the information to an electronic record.
- I weigh everything in the kitchen.
- I can never stop being “hypervigilant” about what I eat.
- My goal is to do 90 to 120 minutes a day of exercise. I learned from six months of marathon training that [it] takes an impossible toll on my family life.

"We really want to build a culture of weight control here." 0:41

"That's really what we want, is to have these kids be obsessed with being a weight controller . . . what we know is that the kids who are successful when they leave here are obsessed . . there's nothing convenient about being a weight controller it really does take that . . obsessive approach to really getting it done and really doing it but it's completely doable." 2:40

"The obsessive quality about it is what works." 11:51

"When I did the triathlon I ate 1800 calories that day - that's more than I should" 12:20

Concerned mother “It seems like they are swapping one eating disorder for another.” 13:00

http://soundcloud.com/sarah-yahm/aosfinalizedwithpan6-3-2
Are we prescribing for fat people what we diagnose as eating disordered in thin people?
Changing Meanings of Fat: Fat, Obesity, Epidemics, and America’s Children

Elise Paradis
Ph.D., M.A. Sociology
Stanford University School of Education
http://www.elisparadis.com
eparadis@stanford.edu
“The Medicalized”: Definition

Medicalization (Conrad 1992; Zola 1983) is the process whereby previously non-medical conditions come under medical purview. It is the consequence of the expansion of the medical profession, and seen in the multiplication of publications, loci of intervention, and claims to authority (Starr 1982).

E.g., Mental illnesses are often discussed as medicalized conditions (e.g., Brumberg 1990; Metzl and Kirkland 2010). Other conditions include baldness (Powell et al. 2005) and erectile dysfunction (Conrad 2005), which were not always seen as medical problems.
Medicalized Fat > Medical Fat
The weight cycling industry wants us all to become its marketers. Will we?
Most people see:

<table>
<thead>
<tr>
<th>HEALTHY</th>
<th>UNHEALTHY</th>
</tr>
</thead>
<tbody>
<tr>
<td>THIN</td>
<td></td>
</tr>
<tr>
<td>FAT</td>
<td></td>
</tr>
</tbody>
</table>

“Headless fatty” phenomenon
Many of us see the dangers of pursuing weight loss in our patients with eating disorders.

<table>
<thead>
<tr>
<th>HEALTHY</th>
<th>UNHEALTHY</th>
</tr>
</thead>
<tbody>
<tr>
<td>THIN</td>
<td></td>
</tr>
<tr>
<td>FAT</td>
<td></td>
</tr>
</tbody>
</table>
And some of us see the fat people having full, satisfying lives as our family, friends, and colleagues.

<table>
<thead>
<tr>
<th>HEALTHY</th>
<th>UNHEALTHY</th>
</tr>
</thead>
<tbody>
<tr>
<td>THIN</td>
<td></td>
</tr>
<tr>
<td>FAT</td>
<td></td>
</tr>
</tbody>
</table>

![Image showing a group of people in a dance class, with a focus on the fat subjects.]
Seeing the *healthiest fat* people and the *sickest thin* people has shaped my point of view. Weight≠health.

<table>
<thead>
<tr>
<th></th>
<th>HEALTHY</th>
<th>UNHEALTHY</th>
</tr>
</thead>
<tbody>
<tr>
<td>THIN</td>
<td>![Fat person exercising]</td>
<td>![Thin person with IV]</td>
</tr>
<tr>
<td>FAT</td>
<td>![Fat person exercising]</td>
<td>![Thin person with IV]</td>
</tr>
</tbody>
</table>

Carol Squires dazzles her *3% Down* friends.
Confirmation bias check

Do you see healthy fat people in your personal or professional life?

Think about whether you witness the full range of body sizes and health outcomes, and how your “sample” affects your ideas about weight and health.
Check your own associations

https://implicit.harvard.edu/implicit/Study?tid=-1
How to Tell a Friend, “You Need to Lose Weight”

Structure House launches unique tool to help people discuss weight loss with loved ones

FOR IMMEDIATE RELEASE

PRLog (Press Release) - Feb 07, 2011 -
DURHAM, N.C. — The nation’s obesity epidemic is growing and impossible to ignore, however, most people struggle to discuss weight loss with a family member or friend. There is a fear of hurting someone you love or losing a friend. Compounding the problem, physicians oftentimes avoid telling a patient to lose weight in order to avoid a potentially negative or unwelcome discussion.

A study conducted during National Obesity Week 2010 revealed that one out of five women are afraid to tell a close friend she needs to lose weight, and only a small portion of those that are not afraid can muster the courage to actually have the conversation. Obesity is a serious health issue and the stigma preventing those from talking to a loved one, could do more harm than good.

“It is not easy to talk to a friend about weight management,” said Dr. Gerard J. Musante, obesity expert and founder of weight loss facility Structure House®. “When a loved one’s health is at stake, your willingness to speak up and show how much you care could make all the difference in the world.”

LAP-BAND Weight Loss Covered by Most PPO Insurance. Free Seminars. Call 1-800-GET-THIN.
1800GetThin.com/Lap-Band

Weight Loss Meal Plans
Order Diet Food Meals Delivered To Your Home. Simple, Easy, Effective!
www.SeattleSutton.com

Sam's Club® Health
Find Tips & Tools to Live Healthy + Free Health Screenings. Learn More!
www.SamaClub.com

How to make friends and family into marketers for the weight cycling industry.
Turning the public into Tools of the Man. Or just tools.

http://www.boston.com/lifestyle/articles/2011/07/15/whats_wrong_with_subjecting_obese_americans_to_the_same_stigmatization_that_smokers_are/?page=full
Resilient responses from people in the fat community: Make stigma into a game! Budget it in! Get five in a row and you win!

Recognize any of these? Note especially, “Won’t someone please think of the children?”

<table>
<thead>
<tr>
<th>I'm sure we can all agree that we are in the middle of an epidemic.</th>
<th>Carrying around X lbs of fat is like wearing a backpack loaded with X lbs.</th>
<th>You just want an excuse to be fat.</th>
<th>I did it! So can you!</th>
<th>You're endangering the rights of dieters!</th>
</tr>
</thead>
<tbody>
<tr>
<td>Won't someone please think of the children?</td>
<td>Fat people are a burden on our health care system.</td>
<td>The law of thermodynamics says you're a liar.</td>
<td>But you're going to die!</td>
<td>Inside every fat person is a thin person trying to get out.</td>
</tr>
<tr>
<td>You must be delusional if you think it's okay to be fat.</td>
<td>Why do you assume that I am thin?</td>
<td>Fat acceptance is just like Big Tobacco.</td>
<td>I'm concerned that you are being too extreme.</td>
<td></td>
</tr>
<tr>
<td>You're just too fat to get laid.</td>
<td>I'm just trying to help.</td>
<td>But I don't wanna be fat!</td>
<td>Fat people have it far too easy in our society.</td>
<td>I want to lose weight and you're being very discouraging by being fat accepting.</td>
</tr>
<tr>
<td>I know you really hate being fat.</td>
<td>You must be a lesbian because you are so fat.</td>
<td>You don't want to hear the truth.</td>
<td>But we have to do something!</td>
<td>You just need to eat less and exercise more.</td>
</tr>
</tbody>
</table>
“Body policing” as motivation?
Scholarship aims to reward students who reach healthy weight

BY LISA SCHENCKER
The Salt Lake Tribune
First published Feb 21 2011 06:12PM
Updated Mar 22, 2011 11:44PM

With childhood obesity a national concern, perhaps it was only a matter of time before a school offered a scholarship for students based not on athletics or academics but on achieving a healthy weight.

A new Utah charter school and a Kaysville gym are partnering to offer scholarships over the next couple of years based on body mass index (BMI), an indicator of body fat based on height and weight. The college scholarships will eventually go to students at Baer Canyon High, a charter school slated to open in the fall with a mission of focusing on medical and sports science, in addition to traditional curriculum.

At least one scholarship will go to the Baer Canyon student whose BMI improves most between enrollment and graduation. Another scholarship will go to the student whose family, collectively, most improves their BMIs between the student’s enrollment and graduation.

How about money?

http://www.sltrib.com/sltrib/home/51282896-76/students-gym-scholarship-baer.html.csp
Give slim kids extra marks says diet guru Dukan

By RFI

France's diet guru Pierre Dukan is urging the French government to grade students on their weight in a bid to combat an increase in obesity.

In a book to be published on Thursday, Dukan suggests that students in their last two years of secondary school be awarded extra marks if they manage to maintain an acceptable Body Mass Index (BMI), a measure of body fat based on height and weight.

How about inflating your grade point average?
Or maybe we just hit you. But hey, it’s your own fat!
Reminds me of the pre-spanking parental disclaimer “I am doing this for your own good!”
Note also that many of the campaigns are being aimed at communities of color, who public health authorities fret are “in denial” and “too comfortable with a range of body sizes.”
More than 40% of Boston Public School students are **overweight or obese.**
A new risk of being fat: Amputation by Photoshop.
“You are in NYC, for God’s sake. Give it to us the right way or we won’t believe you at all.” Cleo Berry, actor.
It’s hard to be a poster child for illness when you’re not.

Sign the petition against the Georgia campaign:
http://www.change.org/petitions/childrens-healthcare-of-atlanta-end-the-stop-sugarcoating-obesity-campaign
Or, we could threaten to or actually take your kids away.
Drug trial to prevent obese kids

Obese pregnant women are to be given a drug to reduce the risk of obesity in their children as part of an NHS trial.

Overweight women supply too much food to a growing baby which can lead to health problems for mother and child.

UK doctors want to try to control this with metformin, which is used to treat diabetes.

Weight Concern said it was an intriguing idea, but ideally women should reach a normal weight before pregnancy.

The researchers leading this study say 15% of pregnant women arriving at many UK hospitals are obese.

It can increase a woman's risk death, pre-eclampsia and of their babies being stillborn or large.

Larger babies are more likely to be obese later in life.

But wouldn’t it be easier to prevent fat kids in the first place?
BBC News 5-9-2011
Teach the little ones that eating too many hamburgers makes you explode!
“Oh NO! It’s those porky, overstuffed American kids!! They’ll sink this old tub!”

“Relax, Noah – we’ll use them as lion feed.”

http://www.gocomics.com/patoliphant/2010/02/24/
Dubai Gym Owner Apologizes After Backlash Over Holocaust-Themed Fitness Campaign

Thursday, January 5, 2012 3:34 pm  |  Written by: Nick Bromberg

A gym advertisement with an explicit Holocaust connection? What could possibly go wrong?

We thought Newt Gingrich’s comparison of failing to be on the Virginia Republican primary ballot to Pearl Harbor was bad. Now a gym owner in Dubai thought a picture of the infamous Auschwitz concentration camp would be a great advertisement poster for his gym.

He thought wrong.

Phil Parkinson, 32, posted a picture to the Circuit Factory’s Facebook page of the railroad tracks leading to Auschwitz with the caption “Where your calories go to die.” Great slogan by itself? Sure. But not when attached to an image like that. The Nazis slaughtered 1.3 million people at Auschwitz.

From The National, in the United Arab Emirates:

Parkinson said he used an image of Auschwitz to advertise weight-loss and exercise classes because "it's like a calorie concentration camp."
What are the health effects of WEIGHT STIGMA?

How can our public health policies be improving health when they are communicating hatred? Hate speech ≠ health speech.
“common sense”? Show me the data.

- We have an obesity “epidemic”
  - 15 pounds heavier on average
  - BMI categories revised downward in 1998
- At the current rate everyone will be obese by 2020
  - No change since 2000
- Losing weight will make you healthier
  - Not if you weight cycle
  - Intentional weight loss and earlier death
- People who lose weight can reduce their risk to that of never-fat people
  - Never been tested, not enough weight loss maintainers
- If everyone eats right and exercises, no one will be fat
- Fat people eat more than thin people
“common sense”? Show me the data.

- US is the fattest country in the world
  - US is 16th
- BMI is a good proxy for health
  - Using BMI misclassifies 51% of the healthy people as unhealthy, 16% of unhealthy as healthy
- Higher BMI shaves years off your life
  - People in the “overweight” range live the longest; mortality does not start to rise until BMI 35-40
- There are safe and effective ways for people to permanently lose weight
- Even if you are healthy as a young fat person, you won’t stay healthy
  - There are healthy fat people at every age including 80-90
  - Nocebo effect and medical “curses”
Consequences of the “obesity epidemic”:

- People buy clothing one size higher
- Children have shorter lifespans than their parents
- All US citizens become “obese” by 2050
- Global environmental collapse from extra gas required to transport fatties
- Global economic collapse from added healthcare costs for fatties who just won’t die

Fat Panic Pie Chart by Deb Burgard 2010. Original “Gay Marriage” Pie Chart author unknown, see Facebook SAGE page photos
Socioeconomic and behavioral risk factors for mortality in a national 19-year prospective study of US adults

Publication Abstract

Many demographic, socioeconomic, and behavioral risk factors predict mortality in the United States. However, very few population-based longitudinal studies are able to investigate simultaneously the impact of a variety of social factors on mortality. We investigated the degree to which demographic characteristics, socioeconomic variables and major health risk factors were associated with mortality in a nationally-representative sample of 3617 U.S. adults from 1986 to 2005, using data from the 4 waves of the Americans’ Changing Lives study. Cox proportional hazard models with time-varying covariates were employed to predict all-cause mortality verified through the National Death Index and death certificate review. The results revealed that low educational attainment was not associated with mortality when income and health risk behaviors were included in the model. The association of low income with mortality remained after controlling for major behavioral risks. Compared to those in the "normal" weight category, neither overweight nor obesity was significantly associated with the risk of mortality. Among adults age 55 and older at baseline, the risk of mortality was actually reduced for those who were overweight (hazard rate ratio = 0.83) and those who were obese (hazard rate ratio = 0.68), controlling for other health risk behaviors and health status.

Having a low level of physical activity was a significant risk factor for mortality (hazard rate ratio = 1.58). The results from this national longitudinal study underscore the need for health policies and clinical interventions focusing on the social and behavioral determinants of health, with a particular focus on income security, smoking prevention/cessation, and physical activity.

DOI:10.1016/j.socscimed.2010.02.003 (Full Text)
Using BMI, 51% of the healthy people are deemed unhealthy.

Translating population correlations to individuals is tricky.

- Let’s imagine that you use BMI as a major predictor of impending hypertension.
- How many **false positives** (people with BMI > 30 who would *not* get hypertension) do we expose to our weight loss lectures, or even unnecessary treatment?
- How many **false negatives** (people with “normal” or “underweight” BMI who *do* get hypertension) do we fail to screen or treat until they have more intractable or more serious problems?
- How much money, time, health is wasted? **How do these biases create the “cost of obesity”?**
Working backwards from a person’s body size to what their health practices must be is like working backwards from a person’s bank account to how hard they must be working.

Sure, when you work harder you generally have more money – but does everyone who works less than you have less? Or more than you have more? We assume people heavier than us must eat more or exercise less, but it doesn’t look that way from the research.
What you can tell by looking at a fat person

- That they are fat
- What they eat
- How much they exercise
- How healthy they are
- If they have an eating disorder

www.danceswithfat.org
BED and body size

Most people in the “overweight” and “obese” BMI categories do not have Binge Eating Disorder. A substantial number of people with Binge Eating Disorder are in the “normal” BMI range.
BED opportunity and risk

- Risk: Fatness will be read as an eating disorder (small, medium, large!)
- Opportunity: Focus on behaviors and quality of life as targets for intervention
- Risk: People with BED will be given diet interventions and delay treatment
- Opportunity: Divorcing body size from eating difficulties

TREAT DISEASE NOT DIVERSITY
“Maybe in DSM-7”

Disorders of the Pursuit of Weight Loss

Severe disturbances in eating behavior and consistent disruption of decision-making based on bodily cues of hunger and satiety that are usually the result of the pursuit of weight loss. Once these practices are initiated, the compensatory mechanisms of the body’s attempt to regulate weight become part of a vicious cycle that either intensifies or collapses, leaving the affected person with certain reliable sequelae.

Diagnostic criteria for Disorder(s) of the Pursuit of Weight Loss

A. Any or all of the following:

(1) **307.1 Restriction** of amount or categories of food that would otherwise be beneficial to the body

(2) **307.5 Binge Eating** - eating an amount of food that is well beyond satiety, accompanied by a sense of being out of control

(3) **307.51 Purging** - compensatory practices such as compulsive exercise, fasting, vomiting, taking diuretics or laxatives, taking stimulant drugs, for the purpose of weight loss or avoiding weight gain
Diagnostic criteria for Disorder(s) of the Pursuit of Weight Loss

A. Any or all of the following:

(1) **307.1 Restriction** of amount or categories of food that would otherwise be beneficial to the body

(2) **307.5 Binge Eating** – eating an amount of food that is well beyond satiety, accompanied by a sense of being out of control

(3) **307.51 Purging** – compensatory practices such as compulsive exercise, fasting, vomiting, taking diuretics or laxatives, taking stimulant drugs, for the purpose of weight loss or avoiding weight gain

B. One or more of the above is/are accompanied by at least three of the four below:

(1) Obsessional thinking about food, exercise, and weight

(2) Hostility directed at the self

(3) Disturbed relationship with body – a sense of the body as the enemy of the wishes to be thinner

(4) Diminishing sense of self-control or increasingly brittle sense of control

In addition, code the frequency of A/B/C in days per week for the last three months, and whether the frequency is increasing, decreasing, stable, or cyclic.

Example: Axis I: 307.1 6 days/week, stable

307.5 3 days/week, ↑

307.51 3 days/week, ↑

Obtain a full history of the symptoms and a weight history. On Axis III, note nutritional deficiencies and medical consequences. On Axis IV, note impact on interpersonal and school/work functioning.
At the crossroads

Why is there a split in our community?

Is it a split in how we conceptualize eating disorders and disordered eating?
What do we see as the central problem?

- Extremes of weight?
- Having a body that elicits stigma?
- The psychological burden of focusing on food and weight?
- Being at war with your body?
- Feeling unworthy unless the external appearances are correct?
- Lack of self-care motivation/skills
- A hostile inner world?
What do we see as the solution to:

... extremes of weight?

A: Weight “normalization” if you are “too thin,” weight loss if you are “too fat”

>Comfortable with the traditional paradigm
>No conflict with “war on obesity”
What do we see as the solution to:

... having a body that elicits stigma?

A: Weight “normalization” if you are “too thin,” weight loss if you are “too fat”
  > Comfortable with the traditional paradigm
  > No conflict with “war on obesity”

or

B: Stigma management skills/Change culture
  > Change the paradigm to HAES
  > The “war on obesity” is part of the problem
What do we see as the solution to:

... the psychological burden of focusing on food and weight?

A: Data say, maintaining weight loss requires “obsession.” Not a solution.

so

B: Intuitive eating

> Change the paradigm to HAES

> The “war on obesity” is part of the problem
What do we see as the solution to:

... being at war with your body?

A: Data say, maintaining weight loss requires ignoring your body. Not a solution.

So

B: Body positive partnership and self-nurturing

> Change the paradigm to HAES
> The “war on obesity” is part of the problem
What do we see as the solution to:

... feeling unworthy unless the external appearances are correct?

A: Weight “normalization” if you are “too thin,” weight loss if you are “too fat”
   > Comfortable with the traditional paradigm
   > No conflict with “war on obesity”
   but does this touch the root insecurity? When are the externals “correct enough” for the anxiety to go away?

B: Work on root causes of self-denigration
   > Change the paradigm to HAES
   > The “war on obesity” is part of the problem
What do we see as the solution to:

... a lack of self-care motivation or skills?

A: Weight “normalization” if you are “too thin,” weight loss if you are “too fat” - you’ll care for the right kind of body

>Comfortable with the traditional paradigm
>No conflict with “war on obesity”

or

B: Commitment to action before attachment, and practice, practice, practice

>Change the paradigm to HAES
>The “war on obesity” is part of the problem
What do we see as the solution to:

... a hostile inner world?

A: Weight “normalization” if you are “too thin,” weight loss if you are “too fat” – get rid of the fat girl!

>Comfortable with the traditional paradigm
> No conflict with “war on obesity”

But the fat girl never goes away. Parts of self don’t go away.

B: Work on relationships between parts of self

>Change the paradigm to HAES
> The “war on obesity” is part of the problem
The restricting/binging script is acted out by two “selves”
### Free association

<table>
<thead>
<tr>
<th>THIN</th>
<th>FAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful</td>
<td>Loser</td>
</tr>
<tr>
<td>Confident</td>
<td>Insecure</td>
</tr>
<tr>
<td>In control</td>
<td>Out of control</td>
</tr>
<tr>
<td>Beautiful</td>
<td>Ugly</td>
</tr>
<tr>
<td>Well-groomed</td>
<td>Slob</td>
</tr>
<tr>
<td>Graceful</td>
<td>Awkward</td>
</tr>
<tr>
<td>Conceited</td>
<td>Grateful for attention</td>
</tr>
<tr>
<td>Happy</td>
<td>Depressed, angry</td>
</tr>
<tr>
<td>Athletic</td>
<td>Couch potato</td>
</tr>
<tr>
<td>No eating problems</td>
<td>Overeater</td>
</tr>
<tr>
<td>Healthy</td>
<td>Impending doom</td>
</tr>
<tr>
<td>Follows advice</td>
<td>Non-compliant</td>
</tr>
<tr>
<td>Good citizens</td>
<td>Cause of terrorism, global warming, economic crisis</td>
</tr>
<tr>
<td>THIN</td>
<td>FAT</td>
</tr>
<tr>
<td>------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Stingy</td>
<td>Generous</td>
</tr>
<tr>
<td>Mean</td>
<td>Jolly</td>
</tr>
<tr>
<td>Poor</td>
<td>Wealthy</td>
</tr>
<tr>
<td>Unhealthy</td>
<td>Healthy</td>
</tr>
<tr>
<td>Ugly</td>
<td>Beautiful</td>
</tr>
</tbody>
</table>
Everyone has a “fat self”

**THIN**
- Successful
- Confident
- In control
- Beautiful
- Well-groomed
- Graceful
- Conceited
- Happy
- Athletic
- No eating problems
- Healthy
- Follows advice
- Good citizen

**FAT**
- Loser
- Insecure
- Out of control
- Ugly
- Slob
- Awkward
- Grateful for attention
- Depressed, angry
- Couch potato
- Overeater
- Impending doom
- Non-compliant
- Scapegoat
Magical thinking

**THIN**

- When I am thin, my life will be perfect
- When I am thin, my life will start. I will let myself get new clothes (etc.)
- If I can just lose weight things will fix themselves
- When I reach my goal weight I can finally relax.
- If everyone eats well and exercises, everyone will be thin!

**FAT**

- If I wasn’t fat, this guy would not have broken up with me
- If I wasn’t fat, I would not have high blood pressure
- If people just lost weight they would have the same risks as people who were never fat
- The other problems this patient has would go away if they just lost weight.
Weight loss as fairy tale

“Happily ever after” =

- I am a totally new person!
- My life is totally great now!
- I used to be depressed but now I am totally confident!
But what happens AFTER after?
After:

- Almost all dieters regain the weight they have lost and sometimes more.
- Almost all dieters stop the practices that they were doing as part of the diet.
- Almost all weight regainers feel embarrassed and like they have failed.
- People are more likely to avoid their doctors.
- The loss/gain cycle is associated with hypertension and increasing waist-hip ratio, risk factors in themselves.
- Almost all clinicians feel frustrated and annoyed.
- The tiny minority who maintain weight loss face the truth about what weight loss changes and what it doesn’t.
- Some people will go on to develop disordered eating or frank eating disorders.
- Almost everyone will have less ability to use their physical cues for eating decisions, in an increasingly stimulating environment.
If the practices are temporary, the health benefits are temporary.
If we stop focusing on weight and start focusing on health, how does the picture change?
If we stop focusing on the *short term* and start focusing on what is *sustainable* for the long term, how does the picture change?
Health at Every Size®(HAES)

www.sizediversityandhealth.org
ASDAH holds the trademark on HAES so that it cannot be co-opted by the weight cycling industry.
Tenets of Health at Every Size

- **Size and self-acceptance** — respect and appreciation for the wonderful diversity of body shapes and sizes (including one’s own!), rather than the pursuit of an idealized weight or shape.

- **Health Enhancement** — attention to emotional, physical, and spiritual well being, without focus on weight loss or achieving a specific “ideal weight.”

- **The pleasure of eating well** — eating based on internal cues of hunger, satiety and appetite, and individual nutritional needs, rather than external food plans or diets.

- **The joy of movement** — encouraging all physical activities for the associated pleasure and health benefits, rather than following a specific routine of regimented exercise for the primary purpose of weight loss.

- **An end to weight bias** — recognition that body shape, size and/or weight are not evidence of any particular way of eating, level of physical activity, personality, psychological issue, or moral character; confirmation that there is beauty and worth in EVERY body.

*by Karin Kratina, PhD, RD and Ellen Shuman. Adapted from Moving Away From Diets (2003), with input from the think tank Show Me The Data*
What is HAES?

- How we define health/illness
  - Not by BMI but rather self-care
- Goals we have for the interaction
  - Development of sustainable practices vs. “makeover”
- Weight neutrality
  - Practices generate definition of “healthy” weight
  - Not assuming practices based on BMI
- Body acceptance and self-care
  - More likely to care for body you accept
- Stereotype management skills
  - Stigma is real, and skills help
- Change discriminatory cultural/political practices
  - Not just individual interventions but social justice/cultural change also
- Critical reading of “obesity epidemic” studies
  - Show me the data
The courage to change the things I can

The things that make people healthier are not dependent on weight loss!

- Good nutrition
- Pleasurable physical activity
- Social support
- Restful sleep
- Access to quality medical care
- Meaningful work
- Physical safety
- A clean environment
- Social justice
- Freedom from stigma
And the wisdom to know the difference

HAES is an approach that evolved from

- The critical and careful reading of thousands of research studies;
- the clinical experience of thousands of healthcare professionals who have grown concerned about traditional weight-centered approaches that do not work;
- the lived experiences of thousands of people who have tried to follow decades of advice about losing weight as a path to health, who ended up less healthy, more discouraged, and more at war with the very bodies they must value enough to sustain the effort to be healthy.
HAES refocuses us on:

- helping people make sustainable self-care practices a lasting feature of their day-to-day lives
- teaching children to treasure their bodies and look to them for irreplaceable wisdom about making day-to-day decisions
- transforming a culture of weight obsession into a body positive, realistic celebration of our human diversity.
HAES refocuses us on educating about the health impact of weight stigma, from

- the world of fashion and advertising
- the doctor's office
- the adoption agency
- the airline ticket counter
- the job interview
- the online dating ads
- the clothing store
- the "I'm so fat" chatter of your best friends.
HAES refocuses us on

getting on with our lives and the hard, rewarding work in front of us.
Good overviews:

www.haescommunity.com and www.lindabacon.org


Full text at: http://ije.oxfordjournals.org/cgi/reprint/35/1/55


Aphramor and Bacon (2011) http://www.nutritionj.com/content/10/1/9
What studies show:

- Medical problems resolving with practices without weight loss
- Practices as sustainable over longer than 2 years
- Calmer and more consistent eating behavior
- Other confounded factors as causal for medical problems at higher BMI
- Failure of fat tissue loss to produce health benefits (liposuction vs. “diet and exercise” interventions)
- Higher BMI as protective at times (“obesity paradox”)
- Implausibility of sustained weight loss for vast majority of people
- Distinctive genetic and metabolic factors that determine BMI (vs. practices under individual control) (continued)
What studies show (cont’d):

- Similar eating practices/eating disorders across the weight spectrum
- Resilience of higher-BMI people despite stigma, and interventions that create resilience for members of stigmatized groups
- Scientific and medical bias among researchers and healthcare providers based on weight stereotyping
- “Nocebo effect” of medical predictions of doom for high-BMI people
- Psychological and medical problems associated with weight dissatisfaction, independent of BMI
- Psychological and medical problems due to weight cycling
- Interference with sustainability of practices from weight loss focus
- Higher risk of eating disorders from weight loss attempts (dieting as “gateway” drug)
Representative Research

- Flegal 2007 (BMI and all-cause mortality)
- Mann 2007 (Long-term weight regain)
- Muennig 2008 (Health depended on gap between perceived and ideal body size, not actual BMI)
- Neumark-Stzainer 2006 and 2011 (Adolescent dieting correlated with higher BMI and disordered eating later, regardless of initial BMI)
- Puhl and Brownell 2006, 2007, 2008 (Weight stigma and ill health)
- Bacon 2005 (HAES intervention showed sustained practices and health benefits)
- Tylka 2006 (Better body image leads to better self-care)
Muennig, 2008

“Our results raise the possibility that some of the effects of the obesity epidemic are related to the way we see our bodies.”

Neumark-Sztainer, 2006

“Adolescents using unhealthful weight-control behaviors at Time 1 increased their body mass index by about 1 unit more than adolescents not using any . . . and were at approximately three times greater risk for being overweight at time 2. . . (They) were also at increased risk for . . . extreme weight-control behaviors such as self-induced vomiting and use of diet pills, laxatives, and diuretics . . .”
Puhl et al., 2006, 2007, 2009

“More frequent exposure to stigma was related to more attempts to cope and higher BMI. Physicians and family members were the most frequent sources of weight bias reported. Frequency of stigmatization was not related to current psychological functioning . . .”

“Participants who believed that weight-based stereotypes were true reported more frequent binge-eating and refusal to diet. . . These findings challenge the notion that stigma may motivate obese individuals to engage in efforts to lose weight.”

www.ruddcenter.org for a list of publications and training for healthcare providers.
Bacon, 2005

- Randomized controlled clinical trial, 6 months of weekly meetings, 6 months of monthly follow up meetings
- Traditional weight loss vs. HAES intervention
- 2-year follow-up
- Health improvements in both groups initially, although no weight loss in HAES group. Over time, weight loss group regained weight and lost health benefits. The HAES group was still exercising and eating well 2 years later and maintained their health benefits.
- Attrition was very low in the HAES group (8%) compared to the weight loss group (42%).

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Diet</th>
<th></th>
<th></th>
<th>HAES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 year</td>
<td>2 year</td>
<td>1 year</td>
<td>2 year</td>
</tr>
<tr>
<td>Weight</td>
<td>Lost (-5 kg)</td>
<td>No change</td>
<td>No change</td>
<td>No change</td>
</tr>
<tr>
<td>Health Improvements</td>
<td>Many Sustained</td>
<td>None Sustained</td>
<td>Many</td>
<td>total cholesterol, LDL, blood pressure, depression, self-esteem</td>
</tr>
<tr>
<td>Health habit Improvements</td>
<td>Many Sustained</td>
<td>None Sustained</td>
<td>Many</td>
<td>activity, disordered eating</td>
</tr>
<tr>
<td>Health Decrement</td>
<td>None</td>
<td>Self-esteem; Felt “like failures”</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Attrition</td>
<td>42%</td>
<td>8%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Tylka, 2006

Intuitive eating is associated with psychological well-being. “Women who accept their bodies are more likely to eat healthy.”
Intuitive Eating

- No more legal/forbidden foods
- As an infant, you knew when you were hungry and when you were full – this is hard-wired and you can find it and turn up the volume now.
- Ice water exercise, building a language for degrees of hunger and fullness
- Every Body part Gets a Vote
- Not a new set of rules, but a principle of nurturing yourself as best you can
- If you are not hungry for food, what else do you need?
What makes it sustainable?

- Your body is not working against you
- You are trying to get more of your needs met, not fewer; there is less settling for food
- Your body is much more consistent homeostatic partner than your conscious, effortful mind. BODIES do not like to be uncomfortable: too hungry or too full. Bodies are usually satisfied with less food than minds, if it is the food they need.
Sustainable Eating

3
Not as tasty but high quality fuel
These are the foods we tend to eat in "healthy" mode to make us feel virtuous, and they may indeed serve our bodies well as fuel. They have a place, but consider whether there a way to make them taste better to you so you will want to eat them.

4
Not that tasty, not quality fuel either
Why eat anything from this quadrant? These foods may be ones you eat out of habit, advertising, custom, etc. – there may be a reason to eat them but they are easiest to let go of if they are problematic as fuel. Consider: foods that are "forbidden" but really don't taste that good; foods that are supposedly "healthy" but really don't do much for your particular body.

1
Highly delicious, high quality fuel
The ideal foods to eat: you want to eat them for the immediate experience as well as the longer-term experience of how they serve to fuel your body.

2
Highly delicious, not as great for fuel
These are the foods we tend to feel guilty eating, but they have a place because they are so good and entertaining. Make sure you are paying attention when you eat them to maximize their entertainment value, and consider whether there is a way to make eating them kinder to your body.
Good Resources

- *Diet Survivors’ Handbook* (Judith Matz and Ellen Frankel)
- *Intuitive Eating* (Evelyn Tribole and Eileen Reisch)
- *Health at Every Size* (Linda Bacon)
We have lots of skills to START but not many to keep coming back. You WILL get injured, ill, stressed, distracted, bored. There are skills to bring yourself back to activity that we should all be learning.

“Intuitive exercise” – your body gets hungry to MOVE.

Exercise as a foreign language – what if we approached it as a life-long skill-building project, collecting all sorts of adventurous experiences and constructing all sorts of contingency plans for real life situations?

Take the money you would have spent on a gym membership and try things.

Use technology to find other people who are near you or who are interested in the same exercise.

Give encouragement to your identity as an athletic person, or a person who loves being outside, or a person who loves recess.
Fitness vs Fatness: Relative Risk of All-Cause Mortality

<table>
<thead>
<tr>
<th>Weight Status</th>
<th>Relative Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal weight and Fit</td>
<td>1</td>
</tr>
<tr>
<td>Normal weight and Unfit</td>
<td>2.2</td>
</tr>
<tr>
<td>Overweight and Fit</td>
<td>1.1</td>
</tr>
<tr>
<td>Overweight and Unfit</td>
<td>2.5</td>
</tr>
<tr>
<td>Obese and Fit</td>
<td>1.1</td>
</tr>
<tr>
<td>Obese and Unfit</td>
<td>3.1</td>
</tr>
</tbody>
</table>

Stereotype management skills

- We respond to the stigmatizing of fat people with one strategy: To take them out of the stigmatized group through weight loss. It does not work, and it makes no dent in the stigma itself.

- Most people who want weight loss are not coming for their health – they are very often in fine health, actually. The lengths people go to to lose weight far outstrip the efforts they typically make to improve their health. They do it to escape the social humiliation – whether they are fat and actually experiencing it, or thin and worrying about experiencing it. If bariatric surgery cured, say, hypertension, in thin people, how many people would sign up for it? There is limited “compliance” with simply taking a daily pill.

- We have ways of helping people who are suffering from stigma – those of us who are alive today have seen groups change our culture our entire lives. Making the world a place where body size does not carry meaning – and is just a characteristic like eye color or height – would make people healthier and happier.
Do not assume that fat people are unhappy, unfulfilled, or interested in losing weight

“The only thing anyone can diagnose, with any certainty, by looking at a fat person, is their own level of stereotype and prejudice toward fat people” (Wann, 2009).
Along with many other obvious and not-so-obvious factors that correlate with health, social support is one of the most robust. Social networks change people’s practices, attitudes, and provide critical safety nets when individuals get in trouble. No amount of insurance or healthcare can take the place of a strong social network. All the components of HAES rely on building strong social support systems.
Size-diversity-friendly offices

- Think through or ask a diverse group of people for feedback
- Have a variety of seating options for people of different sizes
- Consider height, width, depth, arms or armless
- Sturdiness
- Is the seat actually available when the person needs it?
- Wheelchair accessible
- Parking
- Wide doors, large restrooms and stalls
- Exposure to scrutiny, weight-loss or surgery clinics, etc.
- Magazine selection
- Size-friendly resources
- Ask your patients for feedback – is there anything that would make them feel more comfortable and welcome?
Supporting our clients’ activism

- Understanding that experiences of discrimination are not your body’s fault
- Learning from the experiences of other people who have learned how to fight stigma and live good lives
- Taking action on the issues that concern that individual
Attending to stigma is an inescapable aspect of our clinical work.
Sarah, a 17-year old whose BMI is 40, is considering weight loss surgery.

Spencer, a 17-year old in 1952, is gay.

Can Sarah or her parents make an informed choice about the surgery if they cannot imagine a future where Sarah could be healthy, long-lived, and a loved and respected person in society?
How many more people would have died in the AIDS epidemic if we had capitulated to the campaign to “prevent homosexuals” rather than focused on healthy practices for sexually active people?
Treat disease, not diversity
The clinician’s body size is given meaning too

12:00pm session, new client.
12:20pm “I am sorry, but I just have to say this. How are you going to be helpful to me when you obviously have a problem yourself?”

6pm session, longer-term client.
6:20pm “What do you mean, keep the faith that someone out there can love me? What do you know about being fat? You’re an average size woman.”
What stereotype does your body tend to elicit?

Does your body elicit different stereotypes depending on whether the client is thinner or fatter than you are?

What are the lessons of your own weight history?
Having an MD does not protect you from fat stigma.

This story reads like it is a good thing that lower-BMI MDs are more likely to ask their patients to try to lose weight, even though that will lead to weight cycling for most of their patients.

Could it be that higher-BMI MDs are “not as confident” because they are more humble about the limits of changing weight?
Clients want to know if you can help them be at peace in their bodies.
Connect with online community

- Dances with Fat  http://danceswithfat.wordpress.com/blog/
- ASDAH blog  http://healthateveryysizeblog.wordpress.com/
- Shapely Prose archive  http://kateharding.net/
- HAES Community  www.HAEScommunity.org
- Fat Heffalump  http://fatheffalump.wordpress.com/
- Slow Fat Triathlete  http://www.theslowfattriathlete.blogspot.com/
- Revolutions not Resolutions Resources (including STANDards slides !)  http://revolutionsresources.blogspot.com/2011/01/action-item-standards.html?spref=fb
Join an organization

- **BEDA** bedaonline.org
- **ASDAH** sizediversityandhealth.org
- **NAAFA** naafa.org
- **AED** aedweb.org (HAES SIG)
- **SNE** sne.org (Weight Realities Division)
- **EDC** eatingdisorderscoalition.org
Start (or support!) a youth group

- **Boulder Youth Body Alliance**
  - bvsd.org/students/Pages/byba.aspx
  - facebook.com/pages/Boulder-Youth-Body-Alliance/121124328755

- **The Body Positive** thebodypositive.org
Show up!

- On your professional listserv
- In the media
- Write letters
- Lobby
- Professional marketing
- Local schools
- Gyms, sports leagues, parks and recreation, dance studios
The Personal is Political

Take opportunities to challenge the traditional thinking among family, friends, healthcare providers, teachers.

Use props! Start people talking about what really matters.
Tools

- AED Guidelines for Childhood Obesity Programs
  http://aedweb.org/media/Guidelines.cfm

- SNE Weight Realities Division
  Guidelines for Childhood Obesity Programs
  www.sne.org

- Letter to Mrs. Obama from ED orgs
For more information

- Join the HAES SIG and email list:  
  HAESinPractice-subscribe@yahoogroups.com  
  then go to the group’s “Files” section

- Join ASDAH  
  www.sizediversityandhealth.org

- Email debburgard@gmail.com
The Pursuit of Weight Loss

Health at Every Size

The Eating Disorders Community at a Crossroads
Examples of our enlisting in the “War on Obesity”

- Uncritical support for the pursuit of weight loss
  - Including weight loss presentations at conferences
  - Use of BMI as a proxy for healthy weight

- Implying that “obesity” is an eating disorder
  - Including “obesity treatment” in journals about eating disorders
  - Using the language of “AN, BN, and obesity”
  - Equating BED and obesity

- Policy initiatives that further the risk of disordered eating
  - Joint initiatives with organizations trying to prevent obesity or promote bariatric surgery and weight loss programs
  - Staying silent about “childhood obesity prevention”
  - Staying silent about the bullying of fat children in schools

- Creating practice guidelines for pursuing weight loss (APA)
Examples of our enlisting in the “War on Obesity”

- Professional engagements in the pursuit of weight loss
  - Doing screenings for bariatric surgery but not feeling brave enough to advise against it sometimes
  - Presentations on bariatric surgery that are not about the disordered eating symptoms pre- or post-
  - Sharing tips on framing your research as anti-fat to get the obesity grant money
  - Marketing eating disorders programs with weight loss programming
  - Counseling clients with difficulties from weight stigma that the solution is to leave the stigmatized group by losing weight
  - Departing from a stance of WEIGHT NEUTRALITY and support for BODY DIVERSITY
Or, change happens . . .

- Understand that weight stigma is the problem for us all at any size
- No assumptions about practices, health, or worth based on body size
- Help people practice well-being and let their bodies decide what size to be
- Call it the what it is, the weight cycling industry, and refuse to be their marketer
- If you are reviewing for a journal or a conference, insist that all studies that are purporting to show weight loss must have a follow up period after the end of the intervention of at least 2 years
- Demand much more research on weight stigma and weight cycling
- Demand public policy based on health, not hate
- Our own body liberation version of Stonewall?
- Just showing up? Become an “I Stand” poster child
Seeking the Straight and Narrow

Weight Loss and Sexual Reorientation in Evangelical America

Lynne Gerber

296 pages | 6 x 9 | © 2011

Losing weight and changing your sexual orientation are both notoriously difficult to do successfully. Yet many faithful evangelical Christians believe that thinness and heterosexuality are godly ideals—and that God will provide reliable paths toward them for those who fall short. Seeking the Straight and Narrow is a fascinating account of the world of evangelical efforts to alter our strongest bodily desires.
“... Anytime we choose to follow our deepest desires over the protests, the coercion, and the relentless messaging of the dominant discourse, we move more deeply into our empowered, authentic selves.”

Keiko Lane, MFT

http://lgbtpov.frontiersla.com/2012/01/30/lane-the-best-choice-i-ever-made-or-why-queer-is-revolutionary/
There is a community of recovering people watching its leaders

Are we the midwives of our patients’ real selves?

or

the

body

police?
REFUSE TO BE COLONIZED BY THE EATING DISORDER VOICE
I STAND

A partial sampling of the series compiled by Marilyn Wann
January 2012
I STAND

is a grassroots response to the fat-shaming ads promoted in Georgia in the “Strong4Kids” public health campaign.

Here is one of Georgia’s “Stop Sugarcoating It” images:
WARNING
IT'S HARD TO BE A LITTLE GIRL IF YOU'RE NOT.

Stop childhood obesity. strong4life.com
We think

it’s hard to be a little girl when your public health authorities are telling you your body is wrong and they want to eliminate people like you in the coming generation. So we decided to show up.

Each person contributed a photo and a phrase. Marilyn and her Photoshop volunteers turned each one into a new STANDard. If you want to be a part of the series, send your photo and what you stand for to Marilyn@fatso.com!

Enjoy!
I STAND
FOR TEACHING CHILDREN THAT
HEALTHY HABITS INCLUDE LOVING FOOD,
NOT FEARING IT.
Stop weight bigotry. Health At Every Size®
I STAND

FOR YOGIS OF ALL SIZES & ABILITIES
ENJOYING SERENITY & BALANCE.

Stop weight bigotry. Health At Every Size®

STEPHANIE SACK
I STAND
FOR EVERY BODY
LIVING BODACIOUSLY
Stop weight bigotry. Health At Every Size®

EILEEN, PHOTO CREDIT: GWYN PADDEN-LECHTEN, IN THE WOODS STUDIO
WE STAND
FOR UNCONDITIONAL SELF-LOVE.
Stop weight bigotry.  Health At Every Size®
BOULDER YOUTH BODY ALLIANCE
WE STAND
FOR PRIDE IN ALL BELLIES,
BIG AND SMALL.
I STAND

I STAND FOR LIVING YOUR DREAMS IN THE BODY YOU HAVE NOW.

Stop weight bigotry. Health At Every Size®
I STAND FOR TEACHING CHILDREN SELF RESPECT FOR MORE CONFIDENT & TOLERANT GENERATIONS GOING FORWARD.

Stop weight bigotry. Health At Every Size®
I STAND
FOR A REFUSAL TO INTERNALIZE THE RHETORIC OF MORAL PANIC THAT SURROUNDS MY BODY.
Stop weight bigotry. Health At Every Size®
I STAND
FOR SHOWING THE WORLD YOU LOVE YOUR BODY, THUS INSPIRING OTHERS TO LOVE THEIR OWN.
Stop weight bigotry. Health At Every Size®

SUBSTANTIA JONES
I stand for outdoor fun & delicious nutrition for *all* kids.

Stop weight bigotry. Health At Every Size®
I STAND
FOR BREAKING STEREOTYPES PEOPLE MAKE ABOUT PLUS-SIZE WOMEN.

Stop weight bigotry. Health At Every Size®

VIOLET
I STAND AGAINST STIGMA & FAT SHAMING.
FOR NUTRITIOUS, ACCESSIBLE FOOD & SAFE,
JOYFUL PHYSICAL ACTIVITY FOR ALL BODIES.

Stop weight bigotry. Health At Every Size®

KRISTIN DUNKLE, MPH, PhD
I STAND

FOR TEACHING CHILDREN THEY CAN DANCE
AROUND THE WORLD IN ANY SIZE BODY!

Stop weight bigotry. Health At Every Size®

PHOTO: IN HER IMAGE PHOTOGRAPHY
I STAND
FOR THE HEALTH OF MY CHILD & CHILDHOOD FREE OF BULLYING.
Stop weight bigotry. Health At Every Size®
I STAND
FOR LETTING FAT PEOPLE SPEAK FOR THEMSELVES
Stop weight bigotry. Health At Every Size®
CAT PAUSÉ, PHD
I ROLL

FOR SOLIDARITY AT EVERY SIZE,
BECAUSE WE NEED EACH OTHER.

Stop weight bigotry. Health At Every Size®
I STAND
FOR TAKING UP SPACE.
Stop weight bigotry. Health At Every Size®
PATTIE THOMAS
WE STAND
FOR EQUALITY IN HEALTH CARE.
DIVERSITY IN SIZE ≠ DISCRIMINATION IN TREATMENT
Stop weight bigotry. Health At Every Size®
I STAND FOR EXERCISE NOT BEING BORING.

Stop weight bigotry. Health At Every Size®
I STAND
FOR EMPOWERING WHOLENESS IN EVERY BODY. ANTI-FAT MESSAGES HURT PEOPLE OF ALL GENDERS.
Stop weight bigotry. Health At Every Size®
I STAND
FOR HEALTHY CHILDREN OF ALL SIZES. FAT SHAMING IS BAD FOR HEALTH.
Stop weight bigotry. Health At Every Size®

PHOTO: RICHARD SABEL
I STAND

FOR HAVING A POSITIVE BODY IMAGE
FOR LITTLE GIRLS WHO LOOK LIKE ME.

Stop weight bigotry. Health At Every Size®
I STAND

FOR 13-YR-OLD, 220-LB CHEERLEADERS. FAT & ATHLETIC ≠ AN OXYMORON.

Stop weight bigotry. Health At Every Size®
WE STAND
FOR BEAUTIFUL, HEALTHY & SUCCESSFUL CHILDREN OF ALL SIZES.
Stop weight bigotry. Health At Every Size®
I STAND
AGAINST STEREOTYPES
MASQUERADING AS SCIENCE.
Stop weight bigotry.  Health At Every Size®
I STAND
FOR KIDS (AND GROWN-UPS)
WHO COME IN ALL SHAPES AND SIZES
AND ARE ALL BEAUTIFUL.

Stop weight bigotry. Health At Every Size®
I STAND

FOR FRIENDS WHO DON'T CARE
ABOUT A NUMBER ON THE SCALE.

Stop weight bigotry.  Health At Every Size®
I STAND FOR A HATE-FREE FUTURE FOR EVERY BODY.

Stop weight bigotry. Health At Every Size®

CHARLOTTE BILTEKOFF | PHOTO: SARA SEINBERG
I STAND

FOR LOVING YOUR BODY AT ITS FAMINE-RESISTANT FINEST!

Stop weight bigotry. Health At Every Size®
I STAND
FOR BRINGING MY ‘A’ GAME
AT ANY SIZE.

Stop weight bigotry. Health At Every Size®
I STAND
FOR ALL FAT TEENS ACROSS AMERICA WHO GET BULLIED EVERY SINGLE DAY.
Stop weight bigotry. Health At Every Size®
I STAND
AGAINST FIGHTING CHILDOOD OBESITY.
STIGMA = BAD MEDICNE.
every body deserves love.
Stop weight bigotry. Health At Every Size®
I STAND
FOR STRONG BODIES &
CREATIVE MINDS.

Stop weight bigotry. Health At Every Size®
I STAND

AGAINST BULLYING KIDS OF ALL SIZES FOR THEIR WEIGHT.

Stop weight bigotry. Health At Every Size®
I STAND
FOR EMBRACING YOUR INNER BADASS REGARDLESS OF BODY SIZE.
Stop weight bigotry. Health At Every Size®
WE STAND
FOR LOVING THE SKIN YOU’RE IN.
HATE ≠ HEALTH.

Stop weight bigotry. Health At Every Size®
I STAND

FOR FINDING UNCONDITIONAL
JOY IN YOUR BODY!

Stop weight bigotry. Health At Every Size®
WE STAND
FOR LOVING OUR BODIES AND HAVING FUN AT EVERY SIZE.
Stop weight bigotry. Health At Every Size®
WE STAND

FOR PLAYING ANY GAME YOU WANT
IN THE BODY YOU HAVE

Stop weight bigotry. Health At Every Size®
I STAND AGAINST HARMING FAT CHILDREN. HATE ≠ HEALTH.

Stop weight bigotry. Health At Every Size®
I STAND

UP TO THE BULLIES
WHO ARE MEAN TO MY FRIENDS.

Stop weight bigotry. Health At Every Size®