DESIGNING A SET OF BEST PRACTICES FOR THE CARE OF HIGHER WEIGHT PEOPLE

Deb Burgard, PhD, FAED

Existing Guidelines

- NAAFA for medical care (www.naafa.org)
- NAAFA for therapists (www.naafa.org)
- AED for childhood obesity prevention programs (aedweb.org under advocacy)
- Transgender health care (www.wpath.org)
- (Other traditional paradigm guidelines – NICE [UK], APA coming down the pike, ACOG)

ACOG guidelines

- No apparent input from “the obese woman” patient
- Higher weight MDs also seen as failing to discuss weight loss rather than understanding its futility
- Fails to take the implication of weight bias findings and ask, “Does this make our recommendations suspect?”
- Fails to heed decades of research on harms of pursuing weight loss
- Fails to understand the implication of social determinants of health in the obesity research literature, ie that weight stigma, fewer financial resources, racism, limited access to medical care, and biased care when it is received, etc. are causes of higher-weight people’s increased rate of health problems.
- Claims that “classifying obesity as a medical condition can serve to reduce bias toward obese patients . . .”
- Discusses the “increased time and financial burdens” without attributing that to weight bias in the first place.

ACOG guidelines - positives

- The patients whose “obesity is part of their identity and who may not view their obesity as requiring intervention” made it into the discussion and there is grudging acceptance that “Physicians can best serve their patients by remaining their advocates even when obese women choose not to engage in weight-loss efforts . . . Education and counseling . . . ultimately need to respect the patient’s autonomy to make decisions regarding her health care.” (p.4)
- MDs are flatly told that it is “unethical for a physician to refuse to accept a patient or decline to continue care which is in the scope of his or her practice solely because the patient is obese. Refusing to provide care to all obese women as a blanket practice preference is unreasonable and inacceptable.” (p. 3)

Survey

https://www.surveymonkey.com/s/7GX8KGD

Aims:

“This is a grass-roots effort to improve the healthcare system for higher-weight people of every community. My name is Deb Burgard and I am a psychologist and activist interested in improving healthcare. My hope is that the ideas we generate here will culminate in a set of guidelines that all providers of healthcare will use as instructions in culturally competent care that is free of weight bias and discrimination, as well as specifically knowledgeable about the kinds of medical, psychological, economic, social, and cultural issues faced by people of higher weight.”

Thinking broadly:

So, how can we improve healthcare for higher-weight people? There are many aspects to improving care, and we would like you to think broadly and creatively, and to use your own experience or that of loved ones, or those of other higher-weight people, to imagine what would make healthcare - both physical and psychological - competent, accessible, and free of weight bias and stigma. Feel free to suggest not just ideas about how to improve care once you have it, but also, how to improve access to care in the first place.

Take a moment to think about your own experience or that of loved ones or those of other higher-weight people. What are some of the most troubling, as well as the most helpful, aspects of those experiences with the healthcare system? What suggestions might you make on the basis of those experiences?

Main survey questions:

- 1. What would you include in a set of best practice guidelines for higher-weight people?

- 2. How should health care change so that higher-weight people with intersecting identities (experiences related to age, disability, medical or psychological conditions, indigenous heritage, national origin, race, religion, sexual orientation, gender expression, social class, immigration status, and other social identities) are well-served?

Emerging themes

- **Access**
  Access to medical care, period
  Social justice issues impacting access and ability to act on treatment plans
  Discriminatory policies (insurance, workplace) that make it harder to get care.

- **Physical accessibility**
  Convenient locations.
  Comfort in office furnishings.
  Medical equipment sized correctly.

- **Provider attitudes**
  Aware of own biases?
  Efforts to deliver culturally competent care?
  No medicine-by-BMI.
  No inherent pathologizing of higher-weight bodies or people.

- **Medical socialization**
  Be able to say you don't know.
  Meet desperation with compassion and useful tools, not illusions.
  Weight loss is not the go-to treatment plan when all else fails.

Emerging themes, cont'd.

- **Weight-neutral treatment**
  Weight-neutral care, except in the case where higher-weight bodies need a different protocol from lower-weight bodies.
  Offer the same treatment plan as you would offer to a lower-weight person.
  No weight loss goals.
  Recognition of the implausibility of maintaining weight loss with current interventions.
  (Active confronting of weight loss goals?)
  Give lower-weight people the and higher-weight people the chance to be known as individuals.

- **Practice HAES(r) in its social justice-informed incarnation.**

- **Treatment informed by research**
  No interventions without evidence unless informed consent as an "experimental" treatment.

- **Treatment informed by research in how higher-weight bodies might differ**
  Understand how dosages of medications might differ; how the cut offs for what is normal might differ.
  Understand why higher weight can be protective as well as a risk factor.

Emerging themes, cont'd.

- **Treatment that acknowledges stigma and discrimination**
  Help with managing being a member of a stigmatized group.
  Provide networks of caring and competent providers, identifying referrals.
  Providers that make efforts to change cultural, economic, social forces that cause illness.

- **Awareness of social justice issues and health from the beginning of training.**
  Understand how BMI is being used as a cover for racist and classist policies.

- **Healthcare organizations should be connected to the communities they serve.**
  See communities as experts.

- **Principle of informed consent**
  How likely is a poor outcome in 5 years of pursuing weight loss vs. likelihood of worsening health from supposedly weight-related illness?

- **Principle of provider cultural competence**
  Ongoing efforts to learn from members of the community, be aware of weight bias, maybe be certified or take a pledge?

Specific suggestions

- Get rid of BMI.
- Weight not a "vital sign" and routine weighing is dropped.
- No "nocebos" or predictions of doom; provide odds of outcomes in a neutral way.
- Don't judge, don't assume, listen to each person.
- Providers opting out of weight surveillance tracking.
- Courtesy.
- Get to know fat people who are not patients.
- Learn on fat cadavers in med school.
- Develop a specialty in higher-weight care (not weight loss).
- Be mindful of adding info to the medical chart that will result in discrimination - for weight, or psych dx.
- Ask about stigma and bullying when doing history and physical assessment.
- Protect the BMI/height/weight of children as Protected Health Information (PHI) with highest degree of privacy.
- People should be able to audit their own medical records and dispute them.
- Take BP multiple times and never after weighing/having to defend oneself.

ICD-11

“We hope you will take the time to lend your expertise. The results of these studies will directly inform the development of the ICD-11.

To register for WHO’s Global Clinical Practice Network, please click on the link below, or paste it into your internet browser:

http://kuclas.qualtrics.com/SE/?SID=SV_exm6vdPhl8S3hUF

Please address any questions or comments to gcpn@who.int. Thank you for your participation and support.

Sincerely,

Geoffrey M. Reed, Senior Project Officer, Revision of ICD-10 Mental and Behavioural Disorders, Department of Mental Health and Substance Abuse, WHO”

Ongoing

Where are you headed in the next few months and can you include people in the survey who do not usually get a voice?

SUDAPA-subscribe@yahoogroups.com

Debburgard@gmail.com

https://www.surveymonkey.com/s/7GX8KGD


RECESS for ALL!

IMPLICATIONS FOR THE PATIENT WHEN NURSES VIEW WEIGHT AS CAUSING TYPE 2 DIABETES

Cynthia Smith, Darlene McNaughton Flinders University, Adelaide, Australia
Samantha Meyer University of Waterloo, Ontario Canada

Background

This study was designed to explore McNaughton's hypotheses that:

- weight is commonly depicted in various Australian mediums as the primary risk factor or even the cause of type 2 diabetes mellitus (T2DM)

- modifiable risk factors such as diet and exercise are given greater emphasis in the medical encounter, while non-modifiable risk factors such as age and genes have been de-emphasized over time (2013)

In Australia and other jurisdictions, nurses play an important role as part of a health care team in the provision of holistic care and education

Literature Review

Previous literature has suggested that some health care professionals:

- view people who are obese as being at increased risk for several chronic diseases, including T2DM (I. Brown, Thompson, Tod, & Jones, 2006; Rogge & Greenwald, 2004; Zuzelo & Seminara, 2006);
- are known to stigmatize patients who are overweight, in some cases being unaware of their behaviour (I. Brown et al., 2006; I. Brown & Thompson, 2007; Puhl & Heuer, 2009; Zuzelo & Seminara, 2006) which impacts negatively on the patient–provider relationship.

The association between two stigmatized and moralized conditions like obesity and T2DM raises the potential for increased prejudice and may have iatrogenic consequences (McNaughton, 2013a, 2013b; McNaughton & Smith, 2014 in press).

Aims

The aim of this study was twofold:

- through empirical research explore how weight is framed in the medical encounter;
- it determined the implications of these framings for the nurse-client relationship, clients' health outcomes and public health practice.

Methods

- A qualitative case study of people with T2DM (n=15) , and nurses who educate and counsel them in a primary health care setting in South Australia;
- Observation and semi-structured interviews to examine their understandings of the causes and risk factors of T2DM and determine what role if any, overweight and obesity were thought to have on their views of the disease.
- The four participants were Diabetes Resource Nurses, members of a primary health care team that included dietitians, social workers and mental health therapists, all co-located within the GP Plus Service.

Findings – Weight main cause of T2DM

The study found:

- All participants, both clients and nurses, understood overweight as the main cause of T2DM.

When asked to rank the main causes of diabetes, Trisha stated:

Well I think weight management, you know weight, you know when we are carrying extra weight that has come about through a number of things but it is also responsible for then a whole cascade of events within the body including the way insulin is being produced.

Findings – Lifestyle focus

- The participants viewed unhealthy diet and sedentary behaviour as risk factors for T2DM to the exclusion of known causes such as age and family history.
- Consequently, the nurses emphasized behaviour change to self-manage T2DM through ‘lifestyle’ approaches including weight reduction, diet and exercise.

Findings – Weight is unhealthy

- All nurses saw overweight and obesity as unhealthy and described obesity as a "disease" or having disease qualities. One nurse referred to obesity as a chronic disease.

Trisha said that: *"carrying extra weight … is responsible for then a whole cascade of events within the body including the way insulin is being produced. Any weight loss is beneficial".*

Findings – Weight as a comorbidity

- The nurses were asked if their clients had other health issues. Three of the four nurses identified overweight and/or obesity as the health issue.
- Jamie said:

Um, certainly we see a lot of big people, overweight people, so that's a big health issue. Some really big people. Um, yes so that would probably be the most.

Findings – Most clients with T2DM are overweight

- Nurses described the majority of their clients as overweight.

Jennifer replied, *"I would say that 90% of them would be overweight, in the overweight and obese category. You know I said 90%, it's probably higher than that."*

Findings – Nurses practice weight management

- The nurses said that weighing clients and prescribing weight loss was not the focus of their practice, however, the nurses revealed that much of their interaction with clients was about weight management.

Jennifer stated that her practice was to *"motivate people to lose weight and feel better".*

Findings – Age ignored

- All nurses acknowledged that most of their clients were over 50 years of age, yet none of the nurses said that age was a cause, and only one of the nurses identified age as a risk factor for T2DM.

Jennifer said: *"Most would be between the ages of 48 to 72, say, and they have just been diagnosed with diabetes."*

Jamie stated, *"…95 to 99% would be over 50."*

Findings – Social determinants of health

- Three nurses spoke about the “social determinants of health” for example “life stress” and “social isolation” were seen as risk factors for T2DM.
- However, the nurses never discussed the social determinants of health in the group education sessions, and in the observations of the nurse–client counselling sessions nurses seldom took the time to ask clients about their economic or social context.

Implications for the patient, provider, patient-provider relationship, and the health system

- It was common for the nurses to state that clients were responsible for bringing on their disease. They spoke about clients “overeating the wrong foods” and having a “sedentary lifestyle” as behaviours that lead to T2DM.

Trisha said: *“I tell people they’re lucky to get diabetes as their life will be healthier”.*

Implications - Moral

- Moralizing about weight and T2DM was evident in the language of both the nurses and clients. For example, one of the nurses said to a client in the nurse–client consultation, “if you hadn’t been as good as you have been you would have got it [T2DM] 20 years ago”.

Nurses and other health care practitioners often viewed clients who failed to manage their weight and T2DM as “lazy”.

Jennifer said: *I feel I am trying to, helping, trying to you know, to motivate people to lose weight and feel better. Most are motivated at that stage to make some change and so, most make out they’re motivated. But there are some who are just purely not wanting to change at all. … I would also have to say there is a bit of laziness. There is a grain of laziness through that. We all probably think that if only it was easier and we all have excuses and yes I would say that’s the other side of it.*

In some cases, health care practitioners blamed the person for the disease, subsequently clients demonstrated blame when they said they were “*feeling guilty, feeling a failure with diabetes”* and that *“it’s entirely our fault”.*

Implications - Ethical

Lifestyle

- A couple of nurses portrayed the healthy diet as a panacea to prevent the progression and symptoms of diabetes.

- It led some clients to think that changing their lifestyle could “reverse” diabetes.

- These findings have implications for the success of the client's diabetes management and ultimately their health.
- Feelings of guilt, blame and possibly stigma affect the patient's adherence to the prescribed management regime and attendance at appointments.
- Some clients avoided the medical encounter, which has the potential for poor health outcomes.

- In the group education sessions, for example, clients reacted negatively to the nurses' suggestion they take physical activity at a gym, telling the nurses they preferred to engage in [age appropriate] leisure pursuits such as walking.

- Recommendations for managing T2DM should be sensitive to the client's life circumstances.

- The assumption that T2DM is caused by being overweight raises the concern that those who are not overweight may not recognize their symptoms of diabetes such as “fuzzy vision” , assuming that weight is the most significant precursor to the disease (McNaughton, 2013a).

- People may disregard warning symptoms and do not seek appropriate medical advice, such as getting their eyes checked, putting them in further jeopardy for serious complications of the disease (Harris et al., 1992).

Conclusions

- Public health frames the overweight body as a risk factor and in some cases a cause of T2DM, and assumes individual responsibility for the disease.
- This understanding results in the disease being seen as primarily self-inflicted, potentially both blaming the patient and leading to iatrogenic consequences (McNaughton, 2013a; 2013b).

- The nurses did not intend to harm their clients but inadvertently may have done so through their assumptions about weight and T2DM and exclusive emphasis on the lifestyle approach and individual responsibility in the management of the disease.

- The content of the group education sessions focused on factors under individual control, with no reference to the clients' socioeconomic context.

- In this way, health is seen as a "as a responsibility, rather than a right … and subjects are at fault if they are deemed unhealthy, particularly if they had the information about how to achieve health" (Lebesco, 2011, p. 156).

References

Baum, F. (2008). The new public health. Melbourne, Australia: Oxford University Press.

Brown, I., & Thompson, J. (2007). Primary care nurses' attitudes, beliefs and own body size in relation to obesity management. Journal of Advanced Nursing, 60(5), 535–543.

Brown, I., Thompson, J., Tod, A., & Jones, G. (2006). Primary care support for tackling obesity: A qualitative study of the perceptions of patients. British Journal of Medical Practice, 56, 666–672.

Davis, E. (1990). The role of the diabetes nurse educator in improving patient education. The Diabetes Educator, 16(1), 36–38.

Harris, M. I., Klein, M. R., Welborn, T. A., & Knuman, M. W. (1992). Onset of NIDDM occurs at least 4–7 yr before clinical diagnosis. Diabetes Care, 15(7), 815–820.

Illich, I. (2003). Medical nemesis. Journal of Epidemiology and Community Health, 57(12), 919–922.

Lebesco, 2011, p. 156).

McNaughton, D. (2013a). "Diabesity" and the stigmatizing of lifestyle in Australia. In M. McCullough & J. Hardin (Eds.), Reconstructing obesity: The meaning of measures and the measure of meanings (pp. 71–88). New York, NY: Berghahn Books.

McNaughton, D. (2013b). 'Diabesity' down under: overweight and obesity as cultural signifiers for type 2 diabetes mellitus. Critical Public Health, 23, 274–288.

McNaughton, D., & Smith, C. (in press). Diabesity (Dieobesity?) or the 'twin epidemics': Reflections on the iatrogenic consequences of stigmatising lifestyle to reduce the incidence of diabetes mellitus in Canada.

Nettleton, S. (2006). The sociology of health and illness (2nd ed.). Maiden, ME: Polity.

Rogge, M. M, & Greenwald, M. (2004). Obesity, stigma, and civilized oppression. Advances in Nursing Science, 27(4), 301–315.

Zuzelo, P. R., & Seminara, P. (2006). Influence of Registered Nurses' attitudes toward bariatric patients on educational programming effectiveness. The Journal of Continuing Education in Nursing, 37(2), 65–74.

Fattitude

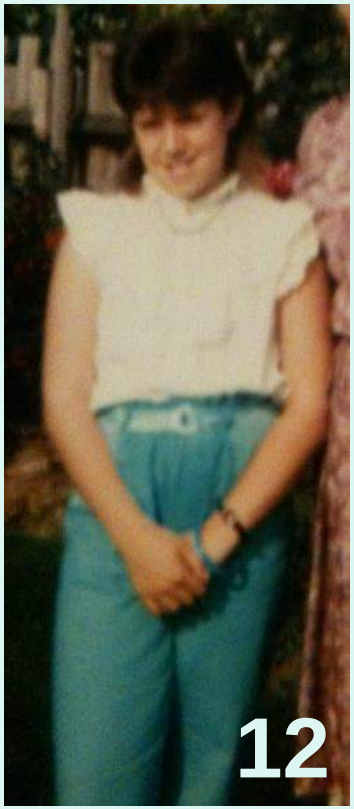
Is it possible for a client to escape the stigma of being fat from their therapist?

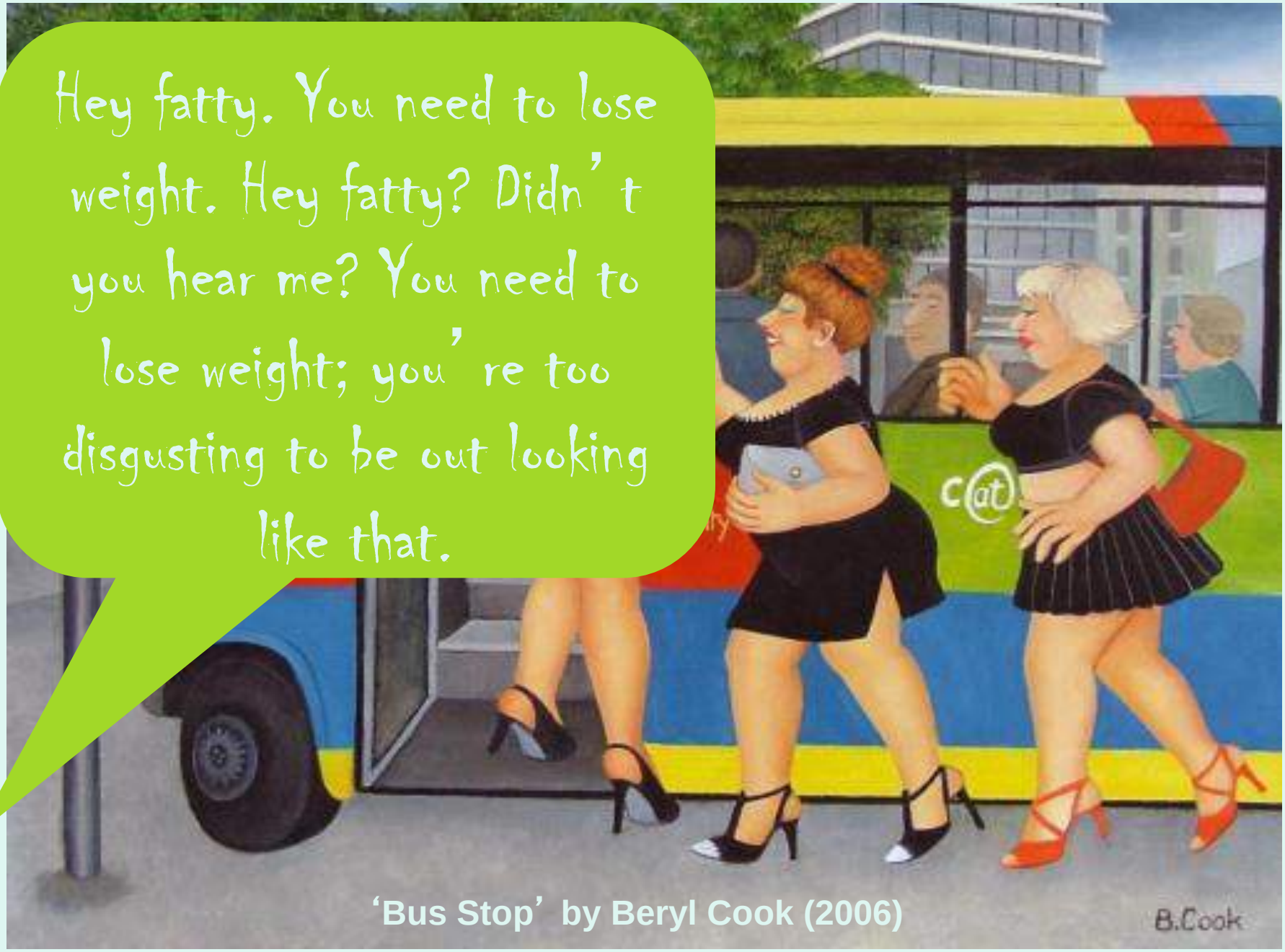
by

Jo Reader, MSc in Counselling, MBACP
University of Bristol
Integrative Counsellor in Private Practice and Secondary School Counsellor

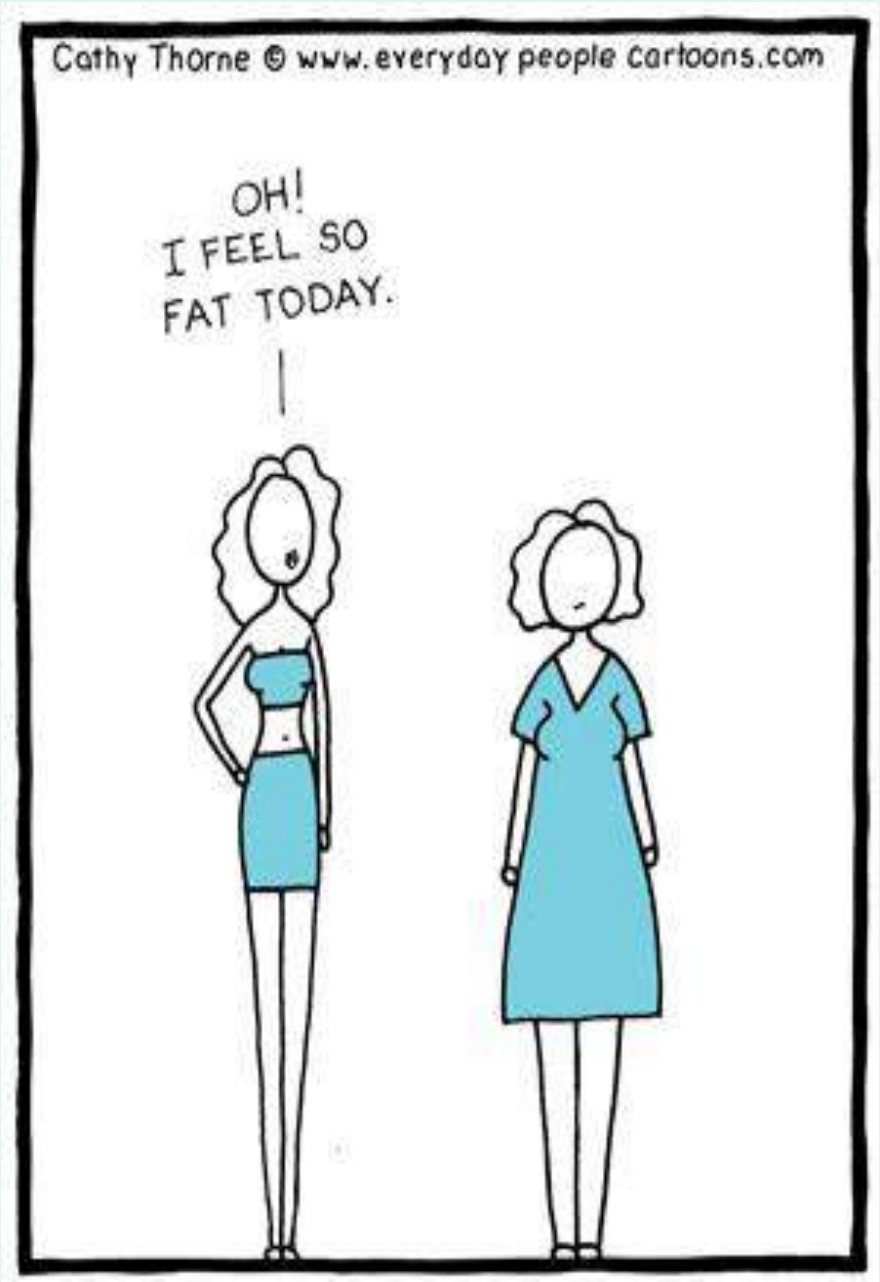
‘Living at the margin’

(Domenech Rodriguez et al, 2008)





'Bus Stop' by Beryl Cook (2006)


Cathy Thorne © www.everyday people cartoons.com
OH!
I FEEL SO
FAT TODAY.


I haven't eaten anything in four days.
Oh my goodness! I wish I had your willpower.
Fitz
© BradFitzpatrick.com

Psychological impact of being fat

- Most immediate and common consequence
- Greatest adverse effect
- Stigmatisation leads to low self-esteem, depression and social discrimination
- Discrimination can lead to significant mental health problems

Tenzer (1989); Wolf (1991); Stunkard and Wadden (1992); Bovey (2000); Royal College of Physicians (2004); Leach (2006)

Is this relevant to all counsellors?

- Brown (1989) found that attitudes towards weight, eating and dieting present in all of *her* female clients, irrespective of size.
- I have numerous female clients, of varying sizes and shapes, presenting with underlying body-image issues.
- The fear of getting fat appears to exist as a potential issue for almost every female client (and some men).
- Brown (1989) found amongst the most aware and open-minded of therapists, that fat oppression ‘is still the norm’.

‘The Counselling Diet’

BACP, October 2008

In a bid to tackle Britain's obesity crisis, those who are overweight need not only to eat less and exercise more, they also need counselling to address the underlying issues, such as comfort eating, behind their weight problem.

Thoughts are Thoughts

'Bryant Park'
(2002)
Beryl Cook

Findings

- Fat prejudice is likely to exist in counsellors
- Clients will detect prejudice
- There is no justification for weight-loss being the goal in a therapeutic setting
- Therapists could benefit from confronting their own feelings about fat and have a good awareness of any weight prejudice towards ourselves or others
- Therapists could afford to become more knowledgeable about weight, size and body image issues from an historical, cultural and political point of view
- Mindfulness can help us stand back from persuasive beliefs and thoughts
- This is a highly relevant topic for therapists which would benefit from further scrutiny.

Recommendations to promote a mentally healthy lifestyle

- validate and honour experiences of surviving discrimination
- help leave the victim behind in order to step into life and take charge of it
- encourage view of self as a confident, capable and physically healthy person at any weight
- focus on capabilities, strengths, potential and acceptance
- raise awareness of unconscious prejudice of fat in counselling training and in guidance/literature.

A Place of Knowing

Additional Resources

NAAFA's Guidelines for Health Care Providers

"Compassion costs nothing" – R. Puhl, PhD

GUIDELINES FOR HEALTHCARE PROVIDERS WHO TREAT FAT PATIENTS

The foundation of a successful healthcare provider-patient relationship is based on mutual respect. A solid partnership between healthcare provider and patient ensures the best medical outcomes. The world continues to become a more diverse place including people of all shapes and sizes. However, many fat patients avoid both seeking preventative health care and medical treatment when they have symptoms, because they assume that they will either be subjected to another lecture on weight loss or that accommodations will not meet their needs.

NAAFA is working to help ensure that healthcare providers provide the best possible care by keeping in mind the special needs of their fat patients.

Philosophy of Health Care

ATTITUDE

- As a responsible healthcare professional, acknowledge each of your patients as an individual. This is especially true for fat patients, who may avoid health care when they feel they are only perceived as being fat, and that the knee-jerk treatment for any problem is to "lose weight."
- Treat fat patients as you would any patient, with tact and concern. Remember that many fat people have had years of negative experiences with healthcare providers, and some have been denied treatment, or given inappropriate treatment, simply because they are fat.
- Engage in health-centered, non-weight focused language (i.e. avoid the term obese)
- Ensure your staff reflects the diverse patient population you serve or seek. Hiring qualified, diverse individuals (which includes size) sets an example that you value diversity in your business practices.
- To demonstrate your commitment to quality health for all patients, it may be necessary to provide size diversity training to your staff.
- Familiarize yourself with the Health At Every Size® principles and appropriately incorporate them into your practice. **http://www.naafaonline.com/dev2/education/haes.html**

WEIGHING PATIENTS

- Do not automatically weigh your patients, unless there is a compelling reason to do so.
- If weighing is necessary, ensure that it takes place in a private setting, and not in the presence of other patients or staff.
- The patient's weight should be recorded silently, free of any commentary.
- Do not assume your patient is interested in weight loss information.

Medical Treatment

DIAGNOSING MEDICAL PROBLEMS

- Respect the patient's health care priorities and address their chief complaint.
- Avoid offering unsolicited weight loss information.
- Remember to perform the same diagnostic tests on your fat patients you would on any other patients for a suspected condition.
- Counsel patients about exercise without linking it to weight. Increased activity improves blood pressure and glucose control, decreases arthritis symptoms and increases overall well-being.

TREATING MEDICAL PROBLEMS

- Do not assume that weight is the cause of all symptoms.
- Do not delay treatment or insist that your patient lose weight prior to receiving treatment.
- Demonstrate care in ordering medication dosages. Some patients react sensitively to small dosages of some drugs, while other drugs require a higher dosage, due to the patient's higher weight.
- Offer to revisit medication decisions if needed, and explain that treatment can prevent long-term complications.

MEDICAL PROCEDURES

- Ensure your patient has access to durable medical equipment (DME) that meets their size needs.
- Have several sizes of blood pressure cuffs readily available. Using a small blood pressure cuff on a bigger arm can produce false readings.
- Have longer needles and tourniquets available in order to draw blood from your patients.
- Utilize appropriate equipment for OB-GYN exams (i.e. longer specula)
- Your lavatory should have a seat that is split in front, to enable patients to more easily hold urine specimen cups in place. A urine specimen collection device with a handle or a "hat" is preferable.
- Closely monitor breathing with sedation if there is increased incidence of sleep apnea and airway problems.

"If shame could cure obesity there wouldn't be a fat woman in the world." – S.Wooley, PhD

Accommodations

WAITING ROOM

- Provide several sturdy armless chairs, couches or benches in your waiting room. Chairs with arms often cannot accommodate a fat patient.
- There should be six to eight inches of space between chairs.
- Sofas should be firm and high enough to ensure that your patients can rise with ease. Exceptionally low and soft sofas can be difficult.
- Be mindful of the information you provide in your waiting rooms and on the walls. Ensure it reflects diversity, including size, to promote a safe and inclusive environment for all your patients.

EXAMINATION ROOM

- Examination tables should be wide, and bolted to the floor or wall, so that they do not tip forward when your fat patient sits on them.
- Provide a sturdy stool for fat patients to assist them in getting onto the examination table.
- Provide larger examining gowns.
- Ensure literature and wall décor reflect a body-positive and weight neutral atmosphere.

http://issuu.com/naafa/docs/naafa_healthcarep_guidelines_2011_v06_screencut

NAAFA Guidelines for Therapists

GUIDELINES FOR THERAPISTS WHO TREAT FAT CLIENTS

There are several assumptions, based on myth and prejudice rather than fact, which many members of our culture--including psychotherapists--believe to be true about fat people. These assumptions affect how therapists view and work with fat people in their practices. It is imperative that therapists recognize and clear out misinformation and bias in order to be most supportive and effective with their clients. We recommend that psychotherapists practice weight neutrality – i.e., make no assumptions based on a person's weight, and not tie goals of treatment to weight outcomes. The following stereotypes are common perceptions that should be challenged.

ASSUMPTION #1: You can determine what people are doing about eating and exercise, just by looking at them. People naturally come in all sizes and shapes. Many fat people eat no more than thin people. Some fat people are extremely active; some thin people are extremely inactive. Therapists must get to know each individual and his or her unique life.

ASSUMPTION #2: Emotional issues cause "excess weight," and once the issues are resolved, the person will lose weight. Humans come in a range of weights, just as they come in a range of heights. There is no evidence that emotional problems are more often the cause of higher weight. The idea that one has to explain why someone is at a higher weight is as nonsensical as trying to explain why someone is tall. There are fat people with emotional problems just as there are thin people with emotional problems, and the problems do not necessarily have anything to do with weight.

ASSUMPTION #2A: Large body size indicates sexual abuse, or a defense against sexuality. Some people who have been sexually abused may be fat; however, we cannot draw any conclusions about a person's psyche based on body size. Many fat people are comfortable with their sexuality and are sexually active.

ASSUMPTION #2B: Fat people must be binge eaters. A small minority of fat people meet the criteria for Binge Eating Disorder (BED), as do a minority of thin people. There are also fat people who are malnourished, restricting, purging, and below their "healthy" weight. People with eating disorders deserve effective treatment and are often able to recover; however, their weight may or may not change in that process. An arbitrarily chosen weight should not be a goal of treatment, since weight is not under direct control. The focus should be on a sustainable, high quality of life, and on helping the person to accept the resulting body size.

ASSUMPTION #3: If a person is distressed and fat, weight loss is the solution. Being the target of weight prejudice can be cause for profound distress; however, the solution to prejudice is to address the prejudice, not the stigmatized characteristic. What would we do for a thin person in similar distress? The quality of support the person is able to give herself, and the quality of support available to her in the world, are key areas of focus. We do not have interventions that lead to lasting weight change, but we do have interventions that free people to be kinder to themselves and mobilize their energy to make their lives better.

ASSUMPTION #4: Fat children must have been abused or neglected. Their problems can be fixed by restrictive dieting and rigorous exercise. Fat children and their parents have been increasingly ostracized in a culture that equates a thin body size with personal value and appropriate parenting. Children often gain extra weight before a growth spurt. Enforcing weight-loss dieting and competitive exercise can lead to rebellion against both, as well as disordered eating. Children need to be supported in using hunger and satiety cues to make decisions about eating, and in valuing their bodies and the variety of bodies in the world. (1)

ASSUMPTION #5: I am not biased against fat people. Research consistently shows that most people, including most healthcare professionals and even those who work closely with fat people, hold negative beliefs about fat people. Please investigate your own associations with weight and bodies of different sizes, including your own body, as essential preparation for working with fat people. (2) Therapists should be able to let go of any agenda to eliminate fatness, and see the beauty in fat bodies and the strengths of fat people living under oppression.

Stereotype Management Skills

There are no personality characteristics that define all fat people; they are as varied as any other demographic group. However, within our extremely negative culture, the fatter the person, the more likely s/he has faced socially sanctioned abuse in daily life. The abuse may come in the form of insults from strangers, family, educators, and acquaintances; surcharges for or denial of insurance or medical treatment, or insistence by medical professionals that weight loss is required for good health and/or for healing any and all presenting complaints; restricted access to jobs, promotions, or advanced education; denial of opportunities to adopt a child; lack of access to adequate seating in theaters, public transportation, restaurants, and even restrooms. As with other survivors of stigma, the fat person may have blamed his or her own body for the poor treatment received at the hands of other people. S/he may have internalized the abuse, with possible consequences such as low self-esteem, depression, social isolation, passivity, or self-hatred. These can be vital areas for therapeutic intervention. As with other survivors of stigma, a fat person may also have used these experiences to develop resilience and powerful skills. Therapists must track both injury and resilience when working with people who face stigma. The skills that oppressed people have used throughout time to lead satisfying lives should be among the solutions used in psychotherapy. The therapist will also be called upon to do his/her part in changing the conditions in the broader world which create oppression in the first place.

http://www.naafaonline.com/dev2/assets/documents/NAAFA_Therapists_2010_v03.pdf

Stereotype Management Skills

Skill set	Examples from your life	Next actions/Comments
Know yourself: • Invest in your own agenda, as an antidote to acting *like* or *unlike* the stereotype. • Cultivate self knowledge that challenges the stereotype. • Foster your drive to be seen as your real self. Remember, you are more lovable than the stereotype!		
Prepare yourself: • Expect stereotyping. Budget it in. • Know the specifics. Understand the typical ways you are likely to be stereotyped, when, where, who. • Blame the process, not your body.		
Impact the situation when possible: • Collect proven ways to "show up" through the fog of the stereotype. What have others done? What has worked before? Think playfully. • Participate in more personal settings and situations where you can contribute. • Seek out or bring along allies when you can. (over)		

Skill areas

Skill set

Know yourself:

- Invest in your own agenda, as an antidote to acting *like* or *unlike* the stereotype.
- Cultivate self knowledge that challenges the stereotype.
- Foster your drive to be seen as your real self. Remember, you are more lovable than the stereotype!

Prepare yourself:

- Expect stereotyping. Budget it in.
- Know the specifics. Understand the typical ways you are likely to be stereotyped, when, where, who.
- Blame the process, not your body.

Impact the situation when possible:

- Collect proven ways to "show up" through the fog of the stereotype. What have others done? What has worked before? Think playfully.
- Participate in more personal settings and situations where you can contribute.
- Seek out or bring along allies when you can. (over)

Skill set

Cultivate compassion:

- Be kind to yourself when you are hurt. Stereotyping hurts no matter how strong your defenses are.
- Remember we all are prone to stereotyping. Try to stay in touch with the other's humanity. Try not to stereotype them back.
- Heal with infusions of playfulness, righteous anger, passion, and humility.

Create new culture:

- Bond with other people who support your identity.
- Evoke them in your mind and let them be present with you.
- Be an activist! Do things that make you feel empowered. Take credit for artfully fighting the stereotype.
- Create new culture with your words, pictures, and deeds.

Study history:

- Research resistance to oppression in all its forms.
- Feel connected to all the humans who came before who created new culture for you. Think about the people who will benefit in the future from your actions now.

Thank you!

Contacts:

Deb Burgard drburgard@hushmail.com

Cynthia Smith CSmith@camosun.bc.ca

Jo Reader jo@joreader.com