Attitudes Toward Disordered Eating and Weight: Important Considerations for Therapists and Health Professionals

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The Culture of Disordered Eating

Several experts in the area of eating problems offer useful definitions of disordered or dysfunctional eating. According to Francis Berg, an internationally-known authority on weight and eating problems: "Dysfunctional eating is eating in irregular and chaotic ways—dieting, fasting, bingeing, skipping meals—or it may mean consistently undereating much less or overeating much more than your body wants or needs. Dysfunctional eating is separated from its normal controls of hunger and satiety, and its normal function of nourishing the body, providing energy, health and good feelings. Instead, it is regulated by external and inappropriate internal controls and seeks to reshape the body or relieve stress."1

Nutritionist Debra Waterhouse writes:

> "…any woman who has some form of an unhealthy relationship with food and her body is a disordered eater. She may be caught in the dietbinge cycle, restricting 'forbidden' foods, feeling guilty after eating, or in a semi-starvation state from chronically undereating, fasting, skipping meals or over exercising."2
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> These definitions encompass much of the dieting, restricting and over exercising behaviors that are considered to be normal, and even caretaking, in our society.

The issue facing clinicians is that we, too, have internalized the values and norms of the culture, which has ramifications for our professional work. For example, most people agree that the images of women portrayed in the media are unrealistic and constitute unhealthy, low body weights. However, the question of "acceptable" weight parameters persists. One colleague recently told us of a patient who was referred for treatment of her anorexia nervosa. As the patient successfully regained weight by integrating a variety of foods into her diet, the psychiatrist told her that she had gained enough and now needed to implement some guidelines in order to lose a few pounds, and then maintain her weight. Understandably, this was upsetting to the patient who was working hard to make peace with her natural body size. It also illustrates how a clinician's internal fears about weight can be projected back onto the client.

We have also spoken with eating disorder professionals who continue to diet for weight loss, and at times admire their clients' "willpower" around food, exemplifying the underlying conflicts that therapists, as members of a fat-phobic culture, may bring to treatment. These types of attitudes reflect a deep fear of fat that requires examination in order to effectively treat individual clients and to make a positive impact on the culture at large. Therapists must carefully consider their own weight biases and challenge the widely held cultural belief system that condones dieting for weight loss.

The Failure of Diets

Despite a $50 billion diet industry promoting countless weight loss methods, approximately 95–98% of all diets fail. The enormous failure rate is due to the inherent nature of diets themselves, although it is the dieter who is blamed for a lack of willpower or commitment. It is essential for professionals to examine the research showing that body weights are not as malleable as most people believe or as diet programs and advertisements claim. Each person has a set point, or natural weight range, where his or her body settles when eating from physiological hunger and engaging in physical activity. Many factors contribute to this natural weight. For example, it is estimated that approximately 50–80% of weight is due to genetics.3 Metabolism, a major component of weight maintenance, is also largely determined by genetic makeup. Evolution also plays an important role in the physiology of weight, with a genetic predisposition to hold on to fat after each period of scarcity to ensure survival in times of famine. When people turn to diets as a means of weight loss, they are met with the strong opposing forces of both genetics and evolution. The body cannot distinguish intentional weight loss from starvation and becomes even more efficient at storing fat for survival purposes, frequently leading to higher than pre-diet weights.4

In spite of extremely high rates of failure, dieting is seen as a positive behavior in our society. In a prospective study of high school girls, those who engaged in dieting behaviors were more likely to gain weight during this 4- year period than their non-dieting counterparts.5 In fact, Glen Gaesser, author of Big Fat Lies, concludes, “A number of studies have shown the inescapable consequence of repetitious cycles of weight loss and gain appear to be even greater accumulations of fat.”6

If body size is largely determined by factors beyond the individual’s control, and the culturally-sanctioned route of dieting for weight loss fails 95% of the time and often leads to weight gain, then how can we, as health professionals, continue to sanction dieting as a positive behavior? If bodies naturally come in a variety of shapes and sizes, are we willing to challenge the idea that trying to change body size to begin with is a useful pursuit?

Is it Better to Be Thin Than Fat?

As a result of the cultural climate in which we live, many people, both health professionals and lay people alike, believe that it is better to be thin than fat. This notion has received ringing endorsement throughout much of the health and advertising industries, moving it to the level of fact, despite research to the contrary.

As therapists using the Health At Every Size model, we do not assume it is better to be thin any more than we assume that it is better to be fat. Large, average, or small people may enjoy physical and mental health, just as it may be compromised in people belonging to each of these groups. The primary reasons people offer to support the argument that “fat is bad and thin is good,” include health concerns, fitting into the culture, attractiveness, and self-esteem. Although an extensive review of the literature is beyond the scope of this article, the following examples illustrate the types of data that therapists and other professionals must familiarize themselves with in order to help clients normalize eating, promote health at every size, and support size diversity.

Health Considerations

It is often assumed that a thin person equals a healthy person, and a fat person equals an unhealthy person. However, most studies show a U-shaped relationship between mortality and weight, with both extremes of the tail ends putting the person at risk. The consistent pattern appears to be that individuals in the lowest weight category are at greatest risk, those in the highest weight category are also at risk, and those in the average to slightly above range are at least risk in terms of mortality.7 Moreover, research has revealed that a weight gain program for the ultra thin in the older population may decrease their risk of early death.8 Conversely, people dieting for weight loss are eight times more likely to develop an eating disorder and risk becoming yo-yo dieters, both of which pose serious medical consequences. 9

Steven Blair, director of research at the Cooper Institute for Aerobic Research in Dallas, has challenged previous studies that have pointed toward fat as a killer. He states,

“It has become abundantly clear to me that in terms of health and longevity, your fitness level is far more important than your weight. If the height/weight charts say you are 5 pounds too heavy or even 50 or more pounds too heavy, it is of little consequence health wise—as long as you are physically fit.”10

To support this notion, he cites the fact that health problems commonly associated with high body weights, such as hypertension, diabetes, and blood lipid disorders, can be controlled without weight loss. According to Blair’s research, being fit offers health benefits whether or not weight is lost. He highlights the deleterious effects of dieting, including an increased risk of heart disease, hypertension and diabetes among those who diet versus their non-dieting counterparts who remain at stable, higher weights. Linda Omichinski, founder of the non-diet program HUGS, poses five important questions that are crucial to consider as you work with clients struggling with food and weight issues:

If there is no proven method of achieving weight loss, then why do we continue to prescribe it?

Are many of the health problems associated with obesity the result of repeated attempts at weight loss?

Is it ethical for us to assist clients in another attempt at weight loss only to set them up for failure as the inevitable weight gain occurs?

Are the 2-5% who maintain the weight loss constantly preoccupied with food and weight? Are they undereating and/or overexercising to maintain this artificial lower weight?

If losing and regaining weight is more harmful than stabilizing at a higher weight, why do we continue to focus on weight as a measure of success?11

Easier to Fit In

The next assumption on our list is that being thin makes it easier to fit into our culture. While there is no doubt that the rewards bestowed on those who are thin are many, is it our role to attempt to change the size of a person exemplifying a subjective, culturally-determined, less-desirable shape? Or should we attempt to change the attitudes that translate into sanctioned discriminatory behavior against people of certain body sizes, just as we have fought against discrimination toward other groups?

Historically, during most of the nineteenth century, fat was in, and plumpness was equated with wealth, status, and superiority. By the late 1800s, as Eastern European immigrants who tended to be shorter and rounder, achieved financial success, the status flipped, and thin became popular while fat became

unpopular. This example illustrates how negative views toward size are culturally induced. The collective decision to exalt one ideal over all other variations has led to discrimination against others based on body size. The consequences of this attitude are enormous.

Weightism, or fat oppression, is one of the last socially-sanctioned prejudices of our time. Fat people are teased, shunned, denied jobs and subjected to various forms of abuse in our society. Fat prejudice and stigmatization are learned early in our culture and have been seen in children as young as 6 years of age. In one study, young girls and boys described silhouettes of an overweight child as “lazy, dirty, stupid, ugly, cheats and lies.”12 As professionals, we must acknowledge weight oppression and help our clients challenge aspects of the culture that reinforce these prejudices. Most importantly, we must stop supporting the cultural dictates that demand thinness as a prerequisite for physical and mental health. The term “size diversity” describes an attitude toward weight that does not contain judgments and assumptions about a person’s physical or psychological health based on body size. Size diversity connotes the idea that people naturally come in all shapes and sizes, and that one size is not inherently better than another. Working in the field of eating and body image issues, we can be on the forefront of embracing the concept of size diversity for our clients and for ourselves.

Attractiveness

Although our culture currently equates the thin body with the attractive body, it is important to understand that definitions of attractiveness vary by time and place. An afternoon in an art museum will reveal the many different ways the female body is portrayed and revered. Artists such as Rubens and Renoir glorify the rotund and abundant woman in her lushness, spirit, and form. In Nigeria, a fat woman is considered the cultural ideal, and her body size is associated with good health, wealth, and allure. In the United States today, it is the thin woman who occupies this status.

Societal messages about ideal body types are dictated by the political, social, and economic climate of a given time cross-culturally, and within the same culture over time. The manifestation of these forces is often played out in a personal struggle with the body. A brief look at the fashionable body and its celebrated form over the past century illustrates the changing ideal within the broader context.

In the late nineteenth century, the plump Victorian ideal served as a reflection of women’s traditional role as housewife and mother. Her plumpness was valued as a sign that her husband had achieved an elevated financial status and could provide well for his family.

During the 1920’s, when women won the right to vote, the flapper look became popular by emphasizing a thin, boyish body with bound breasts. As women were gaining political equality, the ideal woman’s body became more male-like. During the Depression and World War II, as threats of food shortages plagued Americans, a fuller figure was once again in fashion. Naomi Wolf, author of The Beauty Myth, states,”During the repressive 1950’s, women’s natural fullness could be briefly enjoyed once more because their minds were occupied in domestic seclusion. But when women came en masse into male spheres, that pleasure had to be overridden by an urgent social expedient that would make women’s bodies into the prisons that their homes no longer were.”13

Twiggy made her debut in Vogue in 1965, and the ultra-thin ideal was exalted. As women were gaining economic and political ground, they were encouraged to take up less space in the world by becoming concerned with the minutia of their bodies and relentlessly pursuing thinness.14 By the 1990’s, the emaciated “heroin chic” look of Kate Moss epitomized the way in which females were supposed to look

like prepubescent boys and exemplified the culture's discomfort with the gains women had made in the economic and political spheres. The dictates of the ultra-thin ideal fueled the eating disorder epidemic and helped to create the culture of body hatred and food and weight obsessions so apparent today.

Self-Esteem

Many clients report that they want to lose weight to feel better about themselves. Clients are often encouraged to lose weight by professionals, family, and friends who agree that weight loss will result in increased self-esteem. Though dieting is condoned in our culture as a method for self-improvement, dieters are almost always unsuccessful, often resulting in feelings of self-recrimination and shame.

Typically, the effects of caloric restriction include emotional and physical consequences such as depression, fatigue, weakness, irritability, social withdrawal, decreased energy, and a reduced sex drive. The person embarking upon a diet is already experiencing body dissatisfaction and has been taught that weight loss will make them happy. Berg states, "For a time they [dieters] are buoyed by a false sense of hope. Then hopes are dashed once again by the inevitable transgressions and weight gain. Their self-esteem drops lower. Yet as one diet fails, another beckons them on again with false hope. It's a downward spiral of negative self-esteem marked by repeated failure, depressed mood, loss of hope, worsened self-image and commonly, an even stronger resolve to begin another, better diet."15

While dieting negatively impacts a person's self-esteem, research reveals that participation in programs that focus on improving body image and teaching natural eating, rather than restrictive eating, is associated with improved eating behaviors as well as physical and psychological well-being. In 2002, Bacon et al. compared outcomes of those participating in a non-diet group to those in a traditional diet program. They found that both groups showed improvements in metabolic fitness, psychological factors and eating behavior. The dropout rate for the diet group was 41% as compared to 8% in the nondiet group. Furthermore, while self-esteem initially rose for those in the diet group, it was not maintained over time. Conversely, the non-diet participants demonstrated a significant increase in self-esteem one year after treatment was initiated.16

The fat prejudice that pervades our society greatly impacts the self-esteem of people of all sizes and shapes. Either one is already subject to prejudice and discrimination because they are large, or one fears becoming large and therefore being targeted. For the well-being of all people, it is imperative that we understand that self-esteem is related to size only because of faulty cultural messages. In a climate of size diversity, a large person would be no more or less at risk for a decrease in self-esteem than a thin person. Many of the common reasons used to support the idea that it is better to be thin than fat—health reasons, easier to fit in, attractiveness, and self-esteem—are built upon faulty assumptions. Taking time to examine the research and to reflect upon our own beliefs about weight will contribute to an increased awareness of how our views may influence our work with clients. Because the bias against fat is so deeply ingrained in our society, it is crucial to find the space and support to challenge long-standing beliefs about weight and to promote size diversity for ourselves as well as for the people with whom we work.

Normalizing Eating

As professionals challenge weight bias, they can work effectively with clients to develop a healthy relationship with food and their bodies. At this point, they can treat the problem of disordered eating from the stance of normalizing eating rather than focusing on weight loss as a measure of success. We define normal eating as relying upon physiological cues to determine when, what, and how much to eat, most of the time. People eating in this attuned manner use their physical hunger to tell them when to eat, trust their body's natural cravings to guide them in making a match as they choose what to eat, and use feelings of fullness and satisfaction to know when to stop. "...normal eating can also include experiences such as eating occasionally because something looks good, eating past fullness at a special meal, eating in response to an emotion once in awhile, or choosing foods based on nutritional content because this feels caretaking. Attuned eating means that eating for satisfaction is predominant, and experiencing deprivation is virtually non-existent. Attuned eating is a natural skill. It can be relearned by people who have lost touch with their hunger and can be reinforced and nurtured with children so that they maintain this healthy relationship with food throughout their lives."17

It should be noted that attuned eating is flexible and based upon the needs of the individual. Normal eating respects decisions such as being vegetarian, keeping kosher, or choosing to eat or not eat certain foods because of health reasons. The key is that these decisions are based in accordance with what is caretaking to that person, and not on a fear of fat.

Studies support the efficacy of relying on internal cues to direct eating. For example, researcher Leann Birch and her colleagues have consistently found that when children are presented with a wide variety of healthful foods, they are capable of self-regulating their nutritional needs on their own, without external guidance.18 Furthermore, Birch and her colleagues have found that the more parents attempt to control their children's food intake, the less these preschoolers are able to self-regulate over time. They concluded that food restrictions foster consumption in the absence of hunger, while children raised in a non-restrictive environment maintain their natural ability to eat in accordance with internal cues for hunger and satiation.19 This research has implications for adults who rely on external prescriptions to decide when, what, and how much to eat. Practitioners working with disordered eating are familiar with clients who pass up a dessert he or she craves during the day, only to binge later that night.

As clients' eating patterns become organized according to internal signals, they repeatedly experience the physical and psychological satisfaction of meeting needs in a reliable, consistent fashion. Ultimately, this scenario places clients in a strong position to address any emotional issues that may fuel overeating. The deprivation caused by diets or external restrictions almost always leads to overeating. Once deprivation has ended and clients become confident in their ability to feed themselves in an attuned manner, they will develop internal resources required for affect regulation. This ability is a direct result of normalizing eating.

Many therapists believe that once a client understands the underlying feelings that trigger the need to reach for food, the symptoms will disappear. This is not the case. Unless the disordered eating symptoms are dealt with directly, clients may gain a clear picture of the emotional issues that lead to overeating, yet still engage in disordered eating.

Helping clients relearn to eat in a normal or attuned manner requires that the therapist become convinced that eating based on internal cues, without judging one's food choices as "good" or "bad," leads to consistent feeding experiences that encompass a wide variety of food. Clinicians must also understand that eliminating the deprivation caused by dieting ultimately allows people to end overeating and to become calm around food. To the extent that professionals themselves engage in disordered eating,

they will find it difficult to help clients understand and implement these concepts. It is necessary for therapists and other providers to address their own eating and weight issues prior to or in conjunction with offering treatment that encourages normalized eating and an acceptance of bodies varying in shape and size.

Being the Change

As professionals, we have an obligation to provide treatment that improves the lives of our clients, rather than supporting mainstream attitudes and solutions that are harmful. With the explosion of cultural messages to diet, to pursue thinness at all costs, and to fear fat, eating disorders, disordered eating and body hatred have grown to epidemic proportions. We must become positive agents for change. In our 2004 book, Beyond a Shadow of a Diet, we write, "As therapists, we can become knowledgeable about scientific research, the dynamics of compulsive eating, and the relationship between food and emotions, while questioning cultural messages about diet and weight that have become ingrained in our culture. The process of helping clients find freedom from the pain of compulsive eating [and body hatred] is profound and rewarding... If we come together as a therapeutic community to understand how a non-diet, size-accepting [Health At Every Size] approach improves the lives of our clients and the public at large, our potential to create societal change will be immense."20

Mahatma Gandhi explained that we must be the change we want to see in the world. As professionals working with eating problems and weight issues, it is of the utmost importance that we develop a normal relationship with food, and that we exemplify size diversity by honoring both our own bodies and the inherent worth of bodies of all shapes and sizes.

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