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A Weight-Inclusive Approach to Size Acceptance and Healing from Sizeism

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Abstract

Sizeism permeates and shapes how scientific and professional communities—including therapists—perceive, understand, and behave toward anyone considered fat. In this article, we use scientific evidence to argue for the recognition and establishment of fat acceptance to subvert sizeism. We first critically review the Weight Normative Approach, which dominates scientific discourse on weight, despite being based on sizeist assumptions that are discredited by data. We then articulate the tenets of the Weight Inclusive Approach, which honors size diversity and the promotion of wellness within a social justice framework. We end with strategies for therapists to align their practice with the Weight Inclusive Approach.

Keywords: sizeism, weight stigma, size acceptance, Weight Inclusive Approach, Weight Normative Approach, fat positive therapy, obesity

Introduction

In contemporary Western societies, it is “wrong” to be fat. Fat has become synonymous with morbidity, mortality, and moral bankruptcy. The anti-fat sentiment born from this discourse makes corporations a lot of money and shapes how both lay and scientific communities perceive, understand, and behave toward higher weight people. To challenge sizeism, we need to recognize and establish *fat acceptance* as a feminist issue. In this article, we suggest a Weight Inclusive Approach to working with clients as one way of doing so. Our primary aim is to deepen therapists’ understanding of a Weight Inclusive Approach to size acceptance and healing from sizeism for clients of all sizes, but especially for clients with larger bodies. A Weight Inclusive Approach stresses that being fat is not wrong; it is a normal part of human diversity. Here, we elucidate how a Weight Inclusive Approach encapsulates a fundamental right to be fat and may enable feminist therapists to work more effectively with fat clients.

We begin with a critical overview of the Weight Normative Approach to health and wellness that has dominated the cultural and scientific discourse about body size and weight. In particular, we review scientific evidence that refutes the claims of the Weight Normative Approach, and we underscore the global harm associated with the pursuit of weight loss and weight cycling. We then describe the tenets of a Weight Inclusive Approach, and present evidence for how the adoption and implementation of this approach may facilitate genuine healing and liberation from internalized weight stigma and sizeism. Throughout the article, we use *fat* to describe a person, much as we would use *tall*, *short*, and *thin* to describe a person. In our view, if we shun use of the word *fat*, we validate and perpetuate the stigma this term evokes.

The Weight Normative Approach

“When a scientific theory says something is wrong with so many people, perhaps the theory is wrong and not the people.”

-- Mari Ruti (2015, p. 27)

The Weight Normative Approach holds body weight and its management as a central determinant of health and wellness. The emphasis on achieving a certain weight implies there is a specific range of healthy or normal weights, often dictated by body mass index (BMI) categories, which each of us should be striving to attain and maintain. Under this approach, medical and lay judgments about who is healthy or unhealthy, and who is applauded or scolded for their lifestyle, are based on body weight. The Weight Normative Approach is upheld by a number of sizeist assumptions that are rarely challenged despite ample evidence to question their veracity. In fact, scientific evidence has upended or directly discredited key assumptions underlying the Weight Normative Approach. This knowledge is crucial not only for challenging weight normative dogma, but also for changing the sizeist narratives about body weight and fat embedded in the stories clients tell themselves about their bodies.

Assumption #1: The Weight Normative Approach assumes that weight and disease are linearly and causally related—that is, higher weight causes higher risk for disease. The claim that obesity or high BMI causes disease rests almost entirely on correlational data. This is a problem because correlation does not equal causation. Therefore, the scientific data on which these causal claims about the consequences of obesity have been made do not actually support such claims (Campos, Saguy, Ernsberger, Oliver, & Gaesser, 2006; de Gonzalez et al., 2010; Flegal, Kit, Orpana, & Graubard, 2013; Orpana et al., 2010). In fact, contrary to the assumed linear trend, the evidence shows the highest risk for mortality at the extreme ends of the weight spectrum (people with BMIs < 18.5 and BMIs > 35) and the lowest risk of mortality for people with BMIs 25 to <30 (Hotchkiss & Leyland, 2011; Winter, MacInnis, Wattanapenpaiboon, & Nowson, 2014). Thus, the association between weight and mortality is actually U-shaped: the most protected group are in the “overweight” BMI category. People with BMIs less than the reference BMI of 23 show a graded and significantly increased risk of death as BMI *decreased*, regardless of group (Winter et al., 2014). People

with BMIs 18.5 to <25 and BMIs ≥ 30 were comparable to each other in mortality risk, despite the fact that the former group is the only one typically considered to be at a “healthy” weight, and people with BMIs between 25 and <30 had significantly lower mortality risk (Hotchkiss & Leland, 2011), despite the fact that this group is continuously warned about the risks of their weight status. Furthermore, the fact that body weight (typically assessed as BMI) co-occurs with certain conditions (e.g., hypertension, osteoarthritis) does not mean body weight causes those conditions. Other variables (e.g., exercise, weight stigma) are partially or fully responsible for the observed co-occurrence of both a condition and a higher body weight. That is, variables such as a lack of access to quality health care, harassment based on size, a poor diet, and/or sedentary lifestyle can contribute to both weight gain and disease progression. Simply being fatter does not determine health and wellness.

Assumption #2: The Weight Normative Approach assumes that weight is a meaningful proxy for health. Although not the intended purpose, BMI (the ratio of body weight to body height) was adopted as a tool for the assessment of weight and health or “obesity” without an adequate evidence base for doing so. In reality, BMI measures neither fatness nor health—a fact that is widely ignored by the medical establishment that sets health care guidelines and insurance companies that set premiums based on BMI. It simply measures people’s overall weight (regardless of the ratio between fat mass, bone mass, and muscle mass) in relation to their height. It says nothing about body composition, physical strength, or metabolic fitness, let alone behavioral factors (e.g., eating habits, physical activity). In other words, BMI tells us nothing meaningful about a person’s health or lifestyle. For that, we need biomarkers (e.g., blood sugar, lipid levels, blood pressure), as well as information about a person’s habits and life circumstances. These are actual indicators of health and disease, so why not go to them directly instead of using an unreliable proxy? To focus on body size, weight, and shape as a marker of health legitimizes the demonization of fat

people and produces an incomplete, often erroneous, picture of a person's health.

Assumption #3: The Weight Normative Approach assumes that body weight is controllable and therefore should be controlled. “Every institution in our culture—schools, health-care, organizations, media, marketing—promotes a propaganda of weight control”(Burgard, Dykewomon, Rothblum, & Thomas, 2009, p. 337). Moreover, the implication that follows from the premise that weight *can* be controlled is that weight *should* be controlled. Weight management is assumed to be a duty and requirement of good citizenship (Rich & Evans, 2005). Yet, the prescription to “lose weight” is not realistic, meaningful, or justified. To correct one powerful misconception, weight loss is an outcome, not a behavior. Eating breakfast regularly, or becoming more physically active, where feasible and as resources allow, *are* potentially modifiable behaviors that may produce measurable improvements in health, but there is no behavior that guarantees sustainable weight loss. Telling people to lose weight in order to reduce their risk of disease is the equivalent of telling them to stop being fat—as if it were that simple, or desirable.

For most people, genetic, metabolic, and ecological factors have more impact than personal lifestyle choices on body weight. Our body weight is defended against a negative energy balance; our bodies cannot recognize the difference between a diet and a food shortage because, at the cellular level, where the harm is being done, there is no difference. An energy-deprived body lowers its metabolism and increases desire for food to promote energy consumption (MacLean, Bergouignan, Cornier, & Jackman, 2011; Sumithran & Proietto, 2013). Bodies in a negative energy balance burn fat more slowly, and thus hold onto fat more tightly and crave food more often in the absence of hunger as part of the defense against future starvation, a process referred to as metabolic adaptation (Fothergill, Guo, Howard, & Hall, 2016).

At a socio-ecological level, lower-income families and communities have less access and resources to purchase higher-quality, nutrient-rich foods, and instead must purchase refined and

artificial foods that are less expensive and more available to them, thereby posing objective barriers to nutritious energy consumption beyond individual control (Beaulac, Kristjansson, & Cummins, 2009; Drewnowski, 2010; Larson, Story, & Nelson, 2008; Monsivais & Drewnowski, 2007, 2009). Lower-income neighborhoods have less access to safe and nearby recreational areas (e.g., green spaces, playgrounds, bike paths), thereby posing objective barriers to physical activity beyond individual control (Crawford et al., 2008; Estabrooks, Lee, & Gyuresik, 2003; Lumeng, Appugliese, Cabral, Bradley, & Zuckerman, 2006; Neckerman et al., 2009). In sum, far from being a matter of choice and personal control, there are genetic and macrosocial forces that determine body weight, including people's particular social locations, and these forces constrain and shape the control people have over how they live their lives (Germov & Williams, 1996; Vargas, Stines, & Granada, 2017).

Assumption #4: The Weight Normative Approach assumes that significant weight loss is possible for the majority of people and can be sustained. Given the fact that body weight is largely uncontrollable, most people who diet do not sustain or even achieve weight loss, instead dieting predicts weight *gain* over time (Field et al., 2003; Kraschnewski et al., 2010; Mann et al., 2007; Neumark-Sztainer, Wall, Haines, Story, & Eisenberg, 2007; Siahpush et al., 2015), and people feel responsible for their inability to control their weight. A large twin study that controlled for genetic contributions to body weight provided further evidence that dieting episodes dysregulate body weight and do not produce weight loss, which underscores the irony and futility of trying to control weight (Pietilainen, Saarni, Kaprio, & Rissanen, 2012).

Reviews of the evidence for sustained weight loss have shown that most participants do not maintain the behavior changes that produced a short-term weight loss during behavioral weight loss programs (Tomiya et al., 2013); only a small minority demonstrate sustained weight loss 1 year after participation, and even fewer were able to maintain the weight loss after 2 years (Bacon, Stern,

Van Loan, & Keim, 2005; Jeffery et al., 2000). A meta-analytic summary of 29 studies on the effectiveness of structured weight loss programs revealed that 77% of people had regained the weight they had lost 5 years after their participation in a program (Anderson, Konz, Frederich, & Wood, 2001). Nearly a decade and a half later, another review of the long-term evidence on energy-restricted diets for weight loss offered similar findings: The majority of participants in the weight loss interventions experienced gradual weight regain (Langeveld & DeVries, 2015). The authors concluded that extraordinary efforts are required to maintain lost weight, whereby people must chronically fight against powerful biological compensatory processes activated during dieting interventions to keep the body at its preferred weight to optimize functioning. That is, people must keep constant vigil of their energy intake through consistent calorie-restriction and control of the biologically driven urge to eat to compensate for the dieting. Publication bias as well as outcome reporting bias cloud our ability to judge available data. However, what the available data do show is that long-term weight loss is not possible or sustainable for the vast majority of people.

Assumption #5: The Weight Normative Approach assumes that the pursuit of weight loss is safe and leads to even greater health and that the benefits outweigh any risks.

However, the scientific data on weight cycling, or “yo-yo” dieting, challenge this assumption. Weight cycling is fuelled by (a) the failure of diets because our bodies defend against weight loss as described above; (b) bombardment through media by the diet and weight-loss industrial complex on the latest sure-fire method for blasting away the fat forever; and (c) weight controllability beliefs (i.e., we can all alter our body weight if we try hard enough). We have known for nearly 30 years that weight cycling compromises physical and psychological health; it is directly linked to cardio-metabolic disease and mortality in women and men (Brownell & Rodin, 1994; Field et al., 2004; Lissner et al., 1991; Montani, Schutz, & Dulloo, 2015). Weight cycling is specifically associated with loss of muscle tissue, gallstone attacks, weakened bones (Lissner et al., 1991; Nilsson, 2008; Rzehak

et al., 2007), hypertension (Guagnano et al., 2000), chronic inflammation (Strohacker & McFarlin, 2010), and some forms of cancer (Thompson & McTiernan, 2011). Fat people who maintain a stable weight (rather than a fluctuating weight) demonstrate the same level of mortality risk as non-fat people who maintain a stable weight (Rzehak et al., 2007).

Independent of weight cycling, the pursuit of weight loss itself through weight loss attempts compromises physical and psychological health. Energy deprivation in the form of dieting and other calorie-restrictive behaviors is a well-established risk factor for the onset of eating disorders, binge eating, and weight cycling (Liechty & Lee, 2013; Neumark-Sztainer et al., 2006; van Strien, Herman, & Verheijden, 2014). Indeed, the Weight Normative Approach prescribes eating and weight-control practices for fat people that would warrant a diagnosis of an eating disorder in thin people (Burgard, 2009). We consider this hypocrisy morally abhorrent. Weight-loss surgery is also promoted under the guise of guaranteed improvements in health and quality of life, despite the documented risks and detriments to health. In one study, people who underwent weight-loss surgery to improve health reported more negative self-evaluations in the form of body image distortion, body dissatisfaction, and weight stigma (Alegria & Larsen, 2015). In addition, weight-loss surgery has detrimental effects on bone and mineral metabolism, such as bone loss in the hip area (Stein & Silverberg, 2014). Rigid dietary control, which is required after weight-loss surgery, has been associated with its own host of problems, including lower levels of life satisfaction, positive affect, interoceptive awareness, and body appreciation and higher levels of negative affect, binge eating, and food preoccupation (Tylka, Calogero, & Daniélsdóttir, 2015). Ironically, in the name of health, people give up significant health and well-being to be thin. As one study of post-weight-loss surgery participants poignantly described, the fear of regaining weight looms large and brings new tensions and ambivalence to their post-surgery lives (Natvik, Gjengedal, & Raheim, 2013).

Assumption #6: The Weight Normative Approach assumes that stigmatizing fat will

promote health and motivate fat people to lose weight. The importance given to weight under the Weight Normative Approach creates the legitimizing conditions for the stigmatization of fat people. Weight stigmatization refers to the social devaluation, denigration, and marginalization of fat people (see Puhl & King, 2013, for review). Weight stigma is enacted through a number of overt and subtle forms, although always recognizable by its discriminatory nature based on body size and weight, including weight-related teasing, bullying, harassment, violence, hostility, ostracism, and micro-aggressions (e.g., asking fat people if they plan to diet, assuming that a fat person has negative body image, mentioning a diet that a fat person could try). There is no area of people's social existence that is likely to be exempt from weight stigmatization. These experiences occur where people attend school, work, seek medical care, spend leisure time, shop, exercise, eat, and vacation and when they view any form of media (Puhl & King, 2013). Experiences of weight stigma have been linked to a range of chronic conditions, including arteriosclerosis, diabetes, and minor cardiac conditions (Udo, Purcell, & Grilo, 2016). Evidence from two separate, large-cohort studies shows that weight stigmatization is associated with an approximately 60% higher mortality risk over time, even after researchers controlled for body weight, disease burden, and other covariates (Sutin, Stephan, & Terracciano, 2015). Part of the explanation for the health outcomes associated with weight stigmatization involves the body's biochemical response to chronic stress, whereby neuroendocrine modulators, immune system activation, and inflammatory responses create a destructive feedback loop (Beckie, 2012). Research has documented the wear and tear on the body as a result of the stress response associated with weight stigma, an effect known as allostatic load (Puhl & Suh, 2015; Tomiyama, 2014). Perceived weight stigmatization doubles the 10-year risk of high allostatic load, even after researchers control for BMI and other likely confounds, and it is linked with metabolic dysregulation, glucose metabolism, and inflammation (Vadiveloo & Mattei, 2017).

The idea that stigmatizing “anti-obesity” public health campaigns are an effective motivator to behavior change also does not stand up to scrutiny. In addition to the ethical issue of public health professionals deliberately fostering harm (O’Hara & Gregg, 2012) and the potential to exacerbate existing anti-fat attitudes among the public at large (Lewis et al., 2010; Simpson, Griffin, & Mazzeo, 2017), the campaigns are not effective in eliciting healthy behavior change. In two large U.S. studies in which a nationally representative sample of individuals were randomized to view a range of actual weight-focused public health campaigns, the messages that emphasized health behaviors in general without any mention of body weight were viewed as the most motivational. Participants viewed the weight stigmatizing messages most negatively and as the least motivating for engagement in the target behaviours (Puhl, Luedicke, & Peterson, 2013; Puhl, Peterson, & Luedicke, 2013).

Internalized weight stigma is closely linked to people’s experiences of weight stigma. In addition to being stigmatized by others, many fat people have incorporated weight stigma into their own self views; they have endorsed the negative stereotypes about fat people that prevail in society at large and applied them to themselves, with concomitant detriments to their self-worth and identity (Hunger, Major, Blodorn, & Miller, 2015). Internalized weight stigma is associated with a number of indicators of poor health and well-being (e.g., shame, psychological distress; Conradt et al., 2008; Durso & Latner, 2008; Lillis, Luoma, Levin, & Hayes, 2010) and a greater likelihood of engagement in maladaptive coping strategies (Conradt et al., 2008; Lillis et al., 2011). Both experienced and internalized weight stigma have been shown to account for the relationship between BMI and health-related quality of life (Latner, Barile, Durson, & O’Brien, 2014; Lillis et al., 2010) as well as self-reported physical and mental well-being (Hunger & Major 2015). That is, the link between higher body weight and poor health is much higher among individuals who experience stigma from others or from themselves (Muennig, 2008).

The Weight Inclusive Approach

“We take it as self-evident that people take better care of the body that they accept and love *now* than one that they are punishing for being the source of their ill treatment at the hands of other people.”

- Deb Burgard (2009, p. 52)

The Weight Inclusive Approach takes weight out of the equation for wellness and celebrates the natural diversity of bodies. In doing so, this approach aims to disrupt dangerous patterns of body loathing, weight cycling, and body neglect and abuse by empowering people with the knowledge and tools to make peace with their bodies amidst the “war on obesity” (Maine, 2000). The Weight Inclusive Approach has been outlined elsewhere (Tylka et al., 2014), and we distill it here into three basic tenets. The research reviewed in the previous section lends support to each of these tenets. Here we consider them in more depth and then discuss how they can be applied in therapists’ work with clients.

Tenet #1: Body diversity is a natural part of human existence, and people have the right to be fat without prejudice, period. The Weight Normative Approach infringes on basic human rights by assigning pathology and inferiority to fat people. Conversely, the Weight Inclusive Approach asserts people’s right to exist in their bodies without prejudice, stigmatization, marginalization, or oppression. People have the right to live in and enjoy their bodies freely and safely across the weight spectrum. The Weight Inclusive Approach honors the natural variation of body shapes and sizes in the human population. Particular attention is given to honoring the body and size diversity of girls and women, as the experience of weight stigma and fat oppression is highly gendered: Girls and women are subjected to harsher penalties for visibly violating traditional feminine beauty ideals of thinness (Chrisler, 2012). Feminist scholars have shown that, compared to thin women and men of all sizes, fat women are unduly disadvantaged across key areas of daily living, including employment, education, leadership, romantic relationships, and the media (Fikkan

& Rothblum, 2012). Fat women have markedly lower household incomes and lower net worth at retirement than women of average or lower weight, whereas the same economic penalties have not been observed for fat men (Fikkan & Rothblum, 2012). Despite their privilege in many domains, it is important to point out that thin women are indoctrinated in the same sizeist culture, interiorize weight stigma, and thereby are also subject to the restraint of fat oppression.

Fatness tends to be associated with women, the poor, and people of color, thereby positioning poor women of color as the most visible targets for attack in the “war on obesity” (Campos, 2004; Ernsberger, 2009). We do not consider *attacks* as hyperbole because fat oppression also fosters violence against fat women (Royce, 2009). In cultures where fat is hated and feared, fat women are fundamentally unsafe; whether it is in their intimate relationships or encounters with strangers or in the doctor’s office, they feel unable to protect themselves (Gailey, 2014) or garner protection from others (Goodman, 1995; Koppelman, 2003) against sexual and physical violence. According to Gailey’s (2014) analysis of the hyper(in)visible fat women, fat women are both seen and unseen: “Marginalized bodies are not just acknowledged and seen; they are made into a spectacle. They are not simply invisible; they are frequently erased or dismissed from consideration” (p. 167). The unsafe landscape traversed by fat women everyday, fueled by weight stigma and misogyny, constitutes a violation of their fundamental human right to live safely and at peace in their bodies. The Weight Inclusive Approach recognizes and gives voice to this reality for marginalized and stigmatized bodies.

Tenet #2: Health and wellness can be fostered independent of weight—with social determinants of health recognized as primary drivers of population health. As reviewed above and elsewhere (Calogero, Tylka, & Mensinger, 2016; Tylka et al., 2014), a wealth of data supports the fact that health and disease vary across the weight spectrum, and weight and disease are not linearly related. Given the inherent flaws of BMI as a proxy for a person’s health status, and the

fact that most higher weight BMI categories are statistically *less* at risk for early mortality, we find it fundamentally inaccurate to claim that fat is inherently unhealthy. Everyone can improve their health and well-being if they have access to nutritious food, affordable and respectful health care, safe spaces, leisure time, social support, and other necessary resources. The economic and sociopolitical conditions that govern people's lives have the greatest impact on quality of life and longevity. In individualistic cultures, we have been socialized to regard health mostly in terms of behaviors that are seen to support or diminish it. We have come to believe that if we only *do the right thing*, we can all live healthily and happily ever after.

This framework is not only faulty, as our health and longevity is much more heavily impacted by our economic status or identification with a stigmatized group than our food and exercise habits, but it is also unethical, as it masks the social injustice that needs to be recognized and ameliorated. Individuals with the worst health outcomes also have the least amount of personal control over their lives; often, they face economic constraints, oppression, marginalization, violence, and more stressors. Yet, these are the populations most likely to receive the explicit or implicit message that they should “make better choices.” The Weight Inclusive Approach aligns itself within a social justice framework and recognizes that people's health cannot be disentangled from the circumstances of their lives. Working to improve well-being means attending to those circumstances and the systems that dictate them. It also calls for a wider sociocultural effort to address systemic oppression in the form of sizeism, sexism, racism, ableism, and so on; we must acknowledge that without systemic changes, individual improvements will not be sustained.

Tenet #3: Public health and medical interventions should do no harm—they should create living conditions and provide tools that sustain health and wellness for people across the weight spectrum. The principle of “first, do no harm” should be a given for any medical and health-related practice, yet when it comes to fat bodies and the people who inhabit them, the known

harms pale in significance under the promise of weight loss. Again, various medical and health professionals *prescribe* harmful behaviors for fat people that resemble eating disorders (e.g., very low calorie diets, exercising for several hours a day) that they *proscribe* for thin people with eating disorders. Where known harm or the risk of harm exists from an intervention, people should be protected from such harm and not openly subjected to it. The evidence for the harms perpetrated through the pursuit of weight loss and the appalling long-term failure of dieting is overwhelming. Given this evidence, continued attempts by the diet and weight-loss industrial complex to sell people solutions to the “problem” of fatness amounts to experimentation on fat people. Where are the condemnation and outrage toward this unethical behavior and climate? The indoctrination of sizeism runs deep (see Farrell, 2011), and many people have internalized fat hatred and come to blame and shame themselves and others if they or others are fat. Thus, people have been socialized to direct the outrage and condemnation at fat people and themselves rather than at the futile process of weight loss, or at the orchestrators of that process by the media and by medical and mental health professionals.

The Weight Inclusive Approach takes a more conservative, and thus protective, stance on health and wellness by cultivating and encouraging sustainable practices that are known to improve a variety of health and quality of life parameters and do not endanger people’s lives under the guise of health promotion. Furthermore, the Weight Inclusive Approach requires a consideration of the social conditions of an individual’s life to understand where health and wellness might be sustainably improved. Eating patterns, physical activity patterns, leisure activities, availability of social support, stress-reduction practices, and self-care practices are potentially modifiable behaviors that could be harnessed as tools for health promotion. For example, intuitive eaters (i.e., those who adopt a flexible style of eating largely based on following internal hunger and satiety cues rather than emotional or situational cues) benefit from a greater satisfaction with life and improved well-being,

better coping skills, more positive affect, and less negative affect, especially in comparison to those who practice inflexible and rigid eating restraint (Tylka et al., 2015; Tylka & Kroon Van Diest, 2013). However, we must remain cognizant of the fact that these modifications are not possible if people do not have the time, space, opportunity, or finances to support them. Cultivation of resilience in the face of adversity and oppression is critical for fat people to create and secure wellness.

Interventions that Emphasize a Weight Inclusive Approach

There are various manifestations of a Weight Inclusive Approach for health and wellness. Perhaps the most established model is referred to as Health at Every Size® (HAES). The HAES model rejects weight and BMI as indicators of health and emphasizes access to holistic non-stigmatizing health care and self-care as sustainable predictors of health, wellness, and empowerment (Bacon, 2010; O'Hara & Gregg, 2014). Evidence has existed for almost two decades that a HAES-based health intervention is superior to a traditional dieting-based health intervention for improving actual health parameters and increasing adherence to health promotion practices (Bacon et al., 2002; Bacon et al., 2005). Systematic reviews of the literature on the health impact of weight neutral (i.e., inclusive) approaches have revealed its effectiveness on a range of physiological (e.g., blood lipids, blood pressure), psychological (e.g., self-esteem, depression), and behavioral outcomes (e.g., dietary quality, disordered eating, physical activity), and people are much less likely to drop out of a weight-neutral program than a weight-loss program (Bacon & Aphramor, 2011; Cadena-Schlam & Lopez-Guimera, 2014; Clifford et al., 2015; Schaefer & Magnuson, 2014). If the purpose of intervention programs is to improve health and wellness among the participants, and the programs show the same effects (or the weight-neutral programs demonstrate greater improvement than the weight-loss programs), but a weight-neutral program does not subject participants to the stress and harms associated with the pursuit of weight loss, and the practices and benefits of a weight neutral program are more likely to be sustained over time, WHY are we still putting people on diets in the name of

health?

A recently published randomized controlled clinical trial serves as an illustrative example of this comparison between a weight-loss program grounded in the Weight Normative Approach and a weight-neutral program grounded in the Weight Inclusive Approach. Fat women who participated in a weight-neutral program, as compared to a weight-loss program, showed similar or greater improvement on indicators of cardio-metabolic fitness, psychological well-being, and lifestyle behaviors at 6 months and 2 years following the program, without any significant change to weight or BMI (Mensing, Calogero, Stranges, & Tylka, 2016). Women in the weight-loss program did show a sustained reduction in BMI over the 2-year period of the study; however, these women did not sustain improvement on any of the actual health indicators. For example, total cholesterol levels were reduced by 10% (the recommended level of reduction for health benefits) for women in the weight-neutral program, but not for the women in the weight-loss program, which confirms that weight loss did not improve overall cholesterol levels. The weight-neutral program also led to sustained improvement in intuitive eating. There were *no* instances where the weight-neutral program produced a worse outcome than the weight-loss program.

The weight-neutral program was not a panacea for the lived weight stigma of these women. In a deeper examination of the effect of the weight-neutral vs. weight-loss program on adaptive and disordered eating behaviors, internalized weight stigma was a critical factor in whether women showed improvement (Mensing, Calogero, & Tylka, 2016). Improvements in eating behavior in the weight-neutral program were only observed for women with lower internalized weight stigma: They showed significant reductions in disordered eating and sustained improvements in intuitive eating over time. However, women with higher internalized weight stigma did not show any improvement in intuitive or disordered eating behavior independent of the program. A further analysis of the effect of the intervention on physical activity behavior paralleled the effects on eating

behavior (Mensinger & Meadows, 2017). Improvements in moderate-intensity physical activity were observed almost exclusively for those women with lower internalized weight stigma across both programs. These studies highlight the need to target internalized weight stigma directly in health and wellness programs in order to realize the full benefits of a weight neutral program.

How Therapists Can Align Their Practice with the Weight Inclusive Approach

There are many ways for therapists to adopt and implement such an approach with their clients (Bacon, 2010; Omichinski, 1995; Tylka et al., 2014). A core feature and mechanism for change through the adoption of a Weight Inclusive Approach is the cultivation of knowledge and experience regarding sizeism and fat acceptance: (a) What does science actually say about the promise and pursuit of weight loss for health and wellness?, (b) What does science actually say about weight-neutral approaches to health and wellness?, (c) How do we critically evaluate our sizeist culture?, (d) How do we navigate and challenge our own weight stigma and our clients' internalized weight stigma?, (e) How do we care for and accept bodies of all sizes and shapes in a fat-shaming culture?, and (f) How can we participate in the stand against fat oppression? The cultivation of knowledge and experience in all of these areas can empower people to challenge systemic sizeism, demand equality and access, and claim their bodies. Below, we recommend how these areas can be addressed within therapy.

Acknowledge and challenge our own weight bias and sizeist assumptions and attitudes. Our personal perspectives on weight and weight loss will influence how we view our clients and how we talk to them about weight, their bodies, and their well-being. We urge therapists to be cognizant and steer clear of the exaggerated warnings about the “obesity epidemic” (Basham & Luik, 2008; Flegal, 2006; Gard & Wright, 2005; Lyons, 2009), instead of repeating them. These personal reflections and insights are critical in order to avoid colluding with the Weight Normative Approach and perpetuating fat oppression. Therapists should arm themselves with information and

knowledge about sizeism, the dangers of weight-loss programs and weight stigmatization, and how they operate together to oppress fat people and be able to present evidence for the Weight Inclusive Approach to health and wellness. Use thoughtful and respectful language about weight. What language does the client want to use? Be careful not to praise weight loss (e.g., “Wow, look at you! You lost weight and look great!”). Look around the setting where therapy will be held. Do clients feel accommodated and comfortable in this space? For example, do the seats have arms that prohibit a wide range of body sizes? Do the seats have a surface area that only accommodates certain bodies? Are there magazines in the waiting area that emphasize weight loss or reshaping the body? If yes, transformations of that space are needed.

Address weight stigma in all its different forms and intersections with other marginalized identities. Discuss encounters of weight stigma in the everyday lives of clients, including how they may interact with other forms of oppression the clients may experience, and practice strategies for responding to those encounters. Consider implicit biases. Indeed, psychologists have been found to ascribe more pathology, greater symptom severity, and worse prognoses to fat clients than to non-fat clients who present with identical psychological profiles (Davis-Coelho, Waltz, & Davis-Coelho, 2000). Identify supportive, non-shaming, and non-stigmatizing environments for clients to seek out. The scientific evidence is powerful in its capacity to empower fat clients to challenge weight stigma; show them the data on non-sustainable weight loss, the harms of weight cycling and weight stigma, and the promise of HAES and similar models for enhancing quality of life across the board without worrying about weight (Bacon, 2010; Bacon & Aphramor, 2011; Calogero et al., 2016). Discuss in more depth how weight stigma (not weight itself) is the culprit of poor physical and psychological health. Question the financial and political forces operating in the “war against obesity.” Who stands to lose if we start accepting our bodies and rejecting weight loss as a viable and meaningful goal, and who stands to gain?

Address internalized weight stigma and body shame directly and openly, and empower clients to claim their bodies, connect with them, and care for them. Some clients will be relieved to walk away from the weight-loss battle, whereas others will be more resistant and may want to keep up the good fight. Given the deep indoctrination in a sizeist culture, resistance is not surprising and may even afford clients more esteem in the eyes of their peers (Beames, Black, & Vartanian, 2016). How will higher-weight clients reduce feelings of shame and self-stigma, and how will they show others how “good” they are if they give up the goal of losing weight? As we remove the layers of internalized weight stigma, we aim to cultivate a more compassionate self in its place. A Weight Inclusive Approach emphasizes body appreciation, self-compassion, and self-care as critical pathways toward size acceptance and healing from sizeism (Bacon, 2010; Omichinski, 1995; Tylka et al., 2014). We, clients included, cannot liberate ourselves if we continue to neglect and loathe ourselves.

The process of liberating clients from internalized weight stigma and the pressures of size oppression starts with explicit permission to stop trying to lose weight. This permission is often necessary for clients to partner with their bodies to incorporate and benefit from sustainable health promoting practices (Mensing, Calogero, & Tylka, 2016), and there are workbooks geared for this purpose (Tribole & Resch, 2017). However, not everyone has access to these health-promoting practices and the environments free of violence and stigma that are needed to enact them. What therapists can do is build one such environment—their practice—where clients are free of stigma and where they can develop body appreciation and intuitive eating skills to enable them to care for themselves as lovingly as they can.

Stand up and protest fat oppression. Virtually no legislation exists to protect people from weight-based prejudice and discrimination (Friedman & Puhl, 2012). We define activism broadly as working for social and political causes and encouraging other people to work for those causes. This

work can include volunteerism and many other actions that benefit other people, communities, and society at large. Activism builds partnerships, connection, community, and resilience among individuals and groups. Activism is fundamental to social change and the ultimate dismantling of a sizeist system. Everybody can play a role in challenging sizeism through consumer boycotts, selective purchases, letter writing, lobbying, demonstrating, and grassroots campaigning for social change. (See Matacin & Simone, this volume, for additional suggestions.) Higher-weight clients may find it especially healing to engage in size activism.

Imagine if women could take back our bodies and feel comfortable and happy! Imagine if we were encouraged to love our bodies, no matter what. When fat people organize, we are saying that we own our bodies, that they are not for sale to the highest bidder. They are not malleable—they are fat bodies and will stay that way. (Burgard et al., 2009, p. 338)

An exemplary example of size activism is psychologist Carmen Cool's (2012) work in Colorado with the Boulder Youth Alliance Program. Cool trained young people to be body ambassadors to challenge cultural attitudes and beliefs about weight and to lobby for anti-discrimination policies in local schools and beyond. These forms of activism shift the emphasis away from raising self-esteem to increasing power and finding one's voice, which are lost in the objectification and oppression of fat people. There are a number of organizations for clients to explore and join, including the Association for Size Diversity and Health (ASDAH), the National Association to Advance Fat Acceptance (NAAFA), and a number of other grassroots organizations, such as NoLose (NoLose.org) and other size acceptance groups and media outlets, such as Sonya Renee Taylor's *The Body is Not an Apology* (<https://thebodyisnotanapology.com/>), Connie Sobczak and Elizabeth Scott's *The Body Positive* (www.thebodypositive.org), and Deb Burgard's *Body Positive* (www.bodypositive.com).

Since 2014, the International Weight Stigma Conference has provided a unique venue for scientists, scholars, practitioners, and activists to join together to discuss and debate long-standing and current issues related to weight stigma (<https://stigmaconference.com/>). Organized and chaired by psychologist Angela Meadows, this conference takes place annually in various locations and has maintained a low registration fee for participants. The website offers a number of resources for people interested in the topic of weight stigma from a multi-disciplinary perspective, and both therapists and clients may find information there to inform their professional and personal practices.

Conclusion

Inside every fat person is *not* a thin person trying to get out. Inside every fat person is a human being who has the same fundamental right to exist as any other human being. Here we reviewed ways that therapists can uphold body size diversity as a fundamental right by establishing an atmosphere of fat acceptance within their practice and by lifting barriers (experienced and internalized) that limit clients' body freedom through a Weight Inclusive Approach. By celebrating the natural diversity of bodies, the Weight Inclusive Approach disrupts maladaptive attitudes (e.g., body loathing) and behaviors (e.g., poor self-care, weight cycling, body neglect and abuse) brought on by the sizeist culture generally and by the Weight Normative Approach specifically. Grounding the Weight Inclusive Approach within a social justice framework places the emphasis on the social determinants of health and the life circumstances that allow or deny access to resources in order to promote health and wellness for everyone. In these ways, the Weight Inclusive Approach not only adheres to the ethical principle of non-maleficence (Above all, do no harm), but also encapsulates beneficence (Act in the benefit of others by promoting their welfare), justice (Treat people equitably), and respect/autonomy (Promote freedom of action and choice) to provide a more holistic and inclusive pathway to wellness.

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