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Weight Stigma in the Practice of Psychotherapy for Binge Eating Disorder: Guidance for Professionals

Research on Binge Eating Disorder (BED) is still quite incomplete, and the following argument is based mostly on the clinical experience and perspectives of a substantial segment of the psychotherapeutic community who treat BED. We hope that laying out the arguments will lead to better and more useful research by offering contrasting models and testable hypotheses.

The traditional weight-centered, medical-model approach to the treatment of BED has typically defined the target of change as reducing or eliminating binge eating, and reducing weight when the patient's BMI > 25. To most people who accept the model of health as three-squares-a-day and a BMI between 18.5 and 25, this seems straightforward. But what happens when we widen our perspective to include not just the sufferer, but also the environment — specifically the environmental element of *weight stigma?*

Weight stigma, the cultural expression of valuing thinness and devaluing fatness (and all of its behavioral, economic, political, social, health, environmental, and spiritual manifestations), affects both patients and providers.

- We who define and treat disorders are affected by weight stigma in how we feel about our own bodies and those of others.
- We rarely think about how that experience impacts the way we practice.
- We even more rarely think about how weight stigma impacts how we define the "problem" and its solution.

Ironically, this narrow viewpoint traps many clients and healthcare providers in a vicious cycle of "treatment" which reinforces many of the factors that trigger and maintain BED.

Weight Stigma as a Trigger for BED

Our picture of BED is incomplete due to a late start in legitimizing the problem, and a lack of resources for researching disordered eating in general.

- Some people report trying to lose weight before they began bingeing, and others do not.
- BED sufferers often have a BMI < 30, the lower limit for being considered "obese."
- BED, like other full-criteria eating disorder diagnoses, is not common, even among "obese" people [Hudson et al., 2007].

We clearly can't tell by looking at a person's body size how they might be eating. But in doing our clinical work we often find clients coming to us for BED treatment describing experiences predating bingeing that involve some kind of insecurity about food – actual poverty, battles with caregivers over how much they were supposed to eat, frank weight loss dieting, and so on – as well as experiences of weight stigma. Some of these experiences happen to higher-weight people and some to those who are not, since weight stigma can impact people across the weight spectrum.

Sometimes it is simply that we blame our bodies for the cruel acts of others, and because our culture teaches us that eating correctly and having a correct body will prevent such harm, the easy partnership we otherwise have with our bodies in taking care of our needs like hydration or elimination gets poisoned around eating.

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Weight Stigma as a Maintaining Factor of BED

Once a person believes that their body is causing their suffering, through their binge eating or their body size or both, they have lost one of their most effective tools in battling both BED and weight stigma: the partnership with their body.

Bodies are much better at maintaining homeostatic processes than our minds are. Bodies regulate temperature, hydration, pH, fertility, blood glucose, blood pressure, heart rate, and yes, weight. The fact that our culture is so saturated in weight stigma means that for most of the population, the right weight from the point of view of one's body is the wrong weight for a "correct" body. Even though our bodies are regulating, we don't see it that way – we think they are failing, and we don't believe in their wisdom in generating our weight, even if that is the weight we are when we are living in a healthy way.

Because our public health ideas are steeped in unacknowledged weight stigma and bias, we tend to ignore the other determinants of health.

- Instead of assuming that weights would fall in a roughly normal distribution like heights, some weights are arbitrarily designated too high.
- In the transition from population statistics to individual healthcare, instead of trying to determine whether a person is at, below, or above, *their own* healthiest weight, we instead designate a small range as "ideal" and create a range of interventions that (temporarily) suppress the weight of people above that range.

The interventions to suppress weight are also the practices that further remove a person from the partnership with their body in making eating decisions. So instead of knowing to eat because one feels hungry or knowing to stop because one feels satisfied, we train people to ignore their body cues, eating what, when, and how much they are told to. Being able to maintain that disdain of one's body experience is treated as a sign of personal control and success. Ironically, the very entity that is most

likely to moderate eating – because bodies really dislike being uncomfortably empty or uncomfortably full – is disempowered. But bodies are better at survival than minds are at self-denial, at least for most people, and so thankfully ***our bodies usually respond to weight suppression with the impulse to binge, even in the absence of psychological factors***. In the context of weight stigma, people and their healthcare providers view this bingeing response as a failure of discipline. Time to re-institute the regimen and "get back on the diet." And so the merry-go-round continues, and for people who are vulnerable, the opportunity to deepen into full-fledged BED, or fall deeper into its vortex, is offered over and over.

Weight Stigma as a Trigger for Seeking Help

Psychotherapists are very familiar with the sense of desperation that many clients feel about needing to "get eating and weight under control." It is understandable that people living with weight stigma seek to escape it; and it is also true that some of the unhappiness that people are assuming comes from having "incorrect eating" or an "incorrect body" is not going to change by leaving the stigmatized group. Belief in the protective power of a thin future is so strong that people undergo all sorts of dangerous "interventions" and turn over their hard-earned cash, their limited time, and their precious bodies to a useless, harmful weight cycling industry to the tune of over $60 billion.

Weight Stigma as a Reason Providers Fail to Define Goals Beyond Weight Loss

Clients and therapists alike usually share the belief that eating in a more moderate way will lead to an "acceptable" body size and fix the problem of weight stigma by removing the person from the stigmatized group. If we framed the problem as cultural stigma targeting a group of people whose bodies are not the problem, we would presumably come up with a different set of solutions.

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Weight Stigma as a Maintaining Factor of Ineffective Treatment

When clients and healthcare providers embark upon the project of "correcting" binge eating and pursuing weight loss, they often collude in the assumption that the goal is to build a better dieter.

- They see the "problem" of BED as a failure of structure, control, management of binge triggers, emotional regulation, and so on.
- In this view, periods of weight loss and highly-structured intake are viewed as "remission" of binge symptoms.
- But the course of BED is itself frequently characterized by sometimes lengthy overly-structured eating followed by periods of impulsive/frantic overeating. This compliance-rebellion dynamic makes sense when viewed as a response to weight stigma.
- But it takes a healthcare provider who is tracking that dynamic to recognize *that* ***the experience of being a better dieter is actually the prelude to a binge***. Reinforcing the food insecurity just carves the groove of the vicious cycle more deeply.

This area in particular needs research attention, because we have not been able to operationally define recovery from BED in a way that distinguishes actually being at peace with food and rarely feeling a need to use food impulsively or to manage emotions, from simply a reduced frequency of binge eating that is temporarily maintained. Also, the fact that almost no one maintains a suppressed weight for more than a year or two means that there are far more people who are suffering with this process than those meeting the criteria for BED.

When a person accepts the indictment of weight stigma that they have taken/eaten too much, that their body reveals this shame, that their penance is to pay back the debt by eating less than they want to, and that they must wait to participate in life until this debt is repaid, they understand that they are betraying themselves. At the moment they feel desire for more food than they are "allowed" – for

whatever reason – they face a crisis. Which part of the self will act? The compliant, penitent part? The part who is hungry for the food, feeling the need? The angry, betrayed part who is aware of the unfairness of the stigma? It can feel like there is no exit from the conflict inside, visible on the outside in the kaleidoscope of feasting and famine behaviors. And yet, there is an alternative to the restriction/binging cycle. There is an alternative to passively accepting the censure of weight stigma.

Addressing Weight Stigma in Ourselves, our Communities, and our Treatments

Those of us doing psychotherapy with people with BED and hoping to do no harm – and better yet, actually help people – can act in direct opposition to weight stigma. What does this look like?

The Health at Every Size® (HAES) model is one attempt to synthesize these considerations. HAES is weight neutral, shifting the focus off of pursuing weight loss and on to the day-to-day practices that a given person can sustain and find supportive of their well-being. The HAES model also explicitly includes working to change weight stigma in all its guises.

When a person comes to us for help, we can begin by understanding that the desperation they feel is an understandable response to stigma.

- We can refrain from making assumptions based on their body size.
- We can wait to listen to their unique experiences and remember that everything we know about helping someone who is not fat is still available to us in helping someone who is fat.
- We can learn about how our own experiences with weight stigma might be useful or misleading.
- We can start a conversation that is probably not being initiated in any other part of the person's life, about the way weight stigma might be shaping their thoughts, feelings, practices, and relationships.

- We can provide a space for grieving the loss of the imagined future where correct eating and a correct body confer the kind of safety for which we all yearn.
- We can help the person stop waiting to feel worthy in order to act with kindness and responsiveness toward themselves right now, because waiting generates the feelings of unworthiness they are wishing would change.

We can take the model of height and understand that humans come in a wide variety of weights that are not inherently a problem – but that when people feel alienated from their bodies and are suffering in the way they are eating, those are problems. Repairing the relationship with one's body and arriving at the point where most eating decisions result in a satisfying, nourishing experience can be the definition of "returning to normal eating," but that may or may not result in a change in weight. Moreover, achieving this kind of eating requires some self-defense skills in a world that remains toxically judgmental about eating and bodies. To that end, we can include the exploration of stereotype and stigma management skills in our therapeutic work.

We can turn our attention to our own experiences of weight stigma and bias. ***Creating safe places to explore these issues is part of our ethical practice as psychotherapists.*** We are usually already convinced of the importance of examining our own experiences of race, class, sexuality, gender, age, health status, and so on, as just one part of working on the never-ending project of improving our cultural competence. These lived experiences intersect with weight stigma in various ways, as do those of our clients.

Finally, for many of us, it will be obvious that ***fighting the structural inequalities of our society, and weight stigma among them, is part of our work as healers.*** Being able to address the root causes of the suffering we see in our clients means that maybe in the future, fewer people will have to fight back from an eating disorder because fewer people will experience weight stigma in the first place. Let's make that big, fat dream come true!

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Resources:

Binge Eating Disorder Association (BEDA) www.bedaonline.com

Association for Size Diversity and Health (ASDAH) www.sizediversityandhealth.org

Academy for Eating Disorders (AED) www.aedweb.org Health at Every Size SIG

Bruno and Burgard, "Guidelines for Therapists who Treat Fat Patients" at www.NAAFA.org

Burgard, 2010. "What's Weight Got to Do with It? Weight Neutrality in the Health at Every Size Paradigm and Its Implications for Clinical Practice," in Maine, Margo et al (Eds.), *Treatment of Eating Disorders.* Boston: Academic Press.

Burgard, 2009. "Developing Body Trust," in Maine, Margo et al. (Eds.), *Effective Clinical Practice in the Treatment of Eating Disorders: The Heart of the Matter.* NY: Routledge.

Burgard, 2009. "What is Health at Every Size?" in Rothblum, Esther, and Solovay, Sondra (Eds.). *The Fat Studies Reader.* New York: NYU Press.

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